



Department of Health
and Human Services

Office of Inspector General

Semiannual Report

October 1, 1999 - March 31, 2000



June Gibbs Brown
Inspector General

WHO PAYS ?



YOU PAY.

Report Medicare Fraud.



Step One

Call your health care provider for an explanation of unusual or questionable Medicare charges. Most are honest and want to prevent fraud.



Step Two

If you still have questions, call your Medicare insurance company.



Step Three

If you continue to have questions, call the Medicare Fraud Hotline at:

**I-800-HHS-TIPS
(1-800-447-8477)**



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

A MESSAGE FROM THE SECRETARY

At the dawn of a new century, we can look back with pride at the achievements of the Department of Health and Human Services (HHS) over the last several years. And we can look forward with confidence to making even greater strides in improving the quality of the programs and services we provide to the public. To meet that goal, we have to make the most effective and efficient use of our resources and work aggressively to eliminate fraud, waste and abuse in our programs and operations. As part of the HHS team, our Office of Inspector General (OIG) is spearheading those efforts.

Program reform initiatives and intensified efforts to prevent and detect health care fraud, waste and abuse have been hallmarks of this Administration. Our accomplishments in this area have been impressive, with notable increases in civil settlements, criminal convictions and exclusions of dishonest or abusive providers reported by OIG in the last few years. But more important, we have seen real changes in industry behavior as a result of our activities. One clear measure of our effectiveness can be seen in the comparative outcomes of OIGs annual audits of Medicare's fee-for-service payments over the last 4 years. The OIG has worked closely with the Health Care Financing Administration (HCFA) to correct systemic vulnerabilities that accounted for many of the improper payments identified in its initial review conducted in FY 1997. And we have witnessed an enormous improvement over this time, with the estimated rate of improper payments dropping from 14 percent in FY 1996 to less than 8 percent in FY 1999. Other indicators of our success are the decrease in Medicare spending growth and the extension by the Medicare trustees of their estimate of the financial life of the Trust Fund. The trustees, the Congressional Budget Office and other outside commentators have consistently cited increased antifraud and abuse efforts as one of the primary contributing factors in these trends.

I am also extremely pleased that, for the first time, OIG was able to issue an unqualified, or clean audit opinion for the Departments FY 1999 financial statements and those of the major HHS agencies. This result is a significant milestone, particularly for HCFA, and reflects the real progress we have made as a Department in providing reliable financial data.

Another of our critical priorities has been child support enforcement. We have been working harder than ever to ensure that children get the support they are entitled to from their parents, and our accomplishments in this area are impressive. The Administrations criminal child support enforcement initiative Project Save Our Children is showing great success in its pursuit of chronic delinquent parents who owe large sums of child support. Much of this success is attributable to the efforts of OIG and the Administration for Children and Families, Office of Child Support Enforcement, who along with the Department of Justice, State child support agencies and local law enforcement

organizations, have joined in forming regional task forces to identify, investigate and prosecute the most egregious offenders on both the State and Federal levels.

Clearly, we are moving in the right direction on many fronts, but much remains to be done. I am therefore especially grateful to be working with an Inspector General whose assistance and support I can count on to help the Department best fulfill its mission of service to the American people.

A handwritten signature in black ink, appearing to read "D. E. Shalala". The signature is fluid and cursive, with a large initial "D" and "E".

Donna E. Shalala

FOREWORD

This report covers the full range of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) activities for the 6-month period October 1, 1999 to March 31, 2000. An overview of the most significant issues discussed in the report is provided in the Highlights section.

This semiannual period has been a time of substantial progress in our ongoing efforts to protect the integrity of HHS programs and operations and to help minimize Government costs. The successes we have achieved in the area of fraud, waste and abuse are in large measure due to the efforts of a wide variety of individuals and entities, including the Department, the Congress, the Department of Justice (DOJ), other law enforcement agencies, provider groups and program beneficiaries. The accomplishments described in this report are tangible evidence that these partnerships are producing meaningful results.

We have worked diligently with the Department over the past several years to improve financial management and accountability. During this reporting period, for the first time, we were able to issue an unqualified audit opinion on the Departments financial statements. This represents real progress in HHSs efforts to achieve full financial discipline. Our related analysis of Medicare payment errors shows the Health Care Financing Administrations (HCFAs) continued vigilance in monitoring and reducing such errors, although we note that unsupported and medically unnecessary services continue to be pervasive problems. We will continue to work with HCFA in its efforts to reduce improper payments and ensure provider integrity.

Key to our antifraud efforts has been the Health Care Fraud and Abuse Control Program, created under the Health Insurance Portability and Accountability Act, which established a partnership between OIG and DOJ to coordinate Federal, State and local law enforcement health care fraud and abuse activities. This reporting period has seen the culmination of several major joint investigations by OIG and DOJ. Among them was the biggest health care settlement in the Nation's history, in which the world's largest provider of dialysis products and services agreed to pay criminal and civil penalties of \$486 million.

In addition to pursuing prosecution and exclusion in cases where violations have occurred, we have placed a greater emphasis on prevention. We have continued to engage in outreach initiatives designed to help the medical care industry avoid waste, fraud and abuse and to increase its compliance with Medicare rules. Vital efforts in this area include the issuance of industry-specific compliance guidance, special fraud alerts and formal advisory opinions to industry on proposed business practices. We have made our plans, studies and proposals

much more available to interest groups, and have consulted frequently with them to resolve issues and reach common ground. Moreover, in cooperation with the Department Administration on Aging, we have enlisted the assistance of HHS beneficiaries themselves in preventing and detecting fraudulent and abusive practices. Beyond informing and assisting the health care industry and the public, these prevention activities help reduce the Government's enforcement costs and program losses.

We are also working on a number of other compelling issues. For example, we continue to make significant strides in the area of child support. Our work has contributed to the Administration's efforts to increase the rate of paternity establishment in the Nation. Moreover, through the increased scrutiny and cooperation of the Federal, State and local agencies responsible for child support enforcement, we have made it much more difficult for noncustodial parents to ignore their financial obligations to their children. Along with the HHS Office of Child Support Enforcement and others, we have formed multidisciplinary, multijurisdictional task forces to identify, investigate and prosecute criminal nonsupport cases on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. Based on the successes of these multiagency teams in identifying and catching those seriously delinquent in their payments, more children than ever before are getting the help they need and deserve.

Since the beginning of my tenure at HHS, I have pledged to deliver superior performance. I am exceedingly proud of all that OIG has done to make that promise a reality. However, I recognize that improvement is a never-ending process and that we must continue to build on past successes. Therefore, as we embark on the 21st century, I am committed to redoubling OIG's efforts to assist the Department in becoming a stronger and more efficient organization. We will continue to provide our customers with the highest possible level of professionalism and quality through our audits, investigations and inspections and to be a flexible, responsive organization that Government decision-makers can rely on for timely information and advice. In this manner, we will optimize our effectiveness and assure the American taxpayers and the Department's beneficiaries that they are receiving maximum value from HHS programs and operations.

A handwritten signature in black ink that reads "June Gibbs Brown". The signature is written in a cursive style with a large, looping initial "J".

June Gibbs Brown
Inspector General

HIGHLIGHTS

INTRODUCTION

This section highlights the most noteworthy recent accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

STATISTICAL ACCOMPLISHMENTS

For the first half of Fiscal Year (FY) 2000, OIG reported savings of \$9.5 billion, comprised of \$8.4 billion in implemented recommendations and other actions to put funds to better use, \$40.5 million in audit disallowances and \$968.1 million in investigative receivables. (See Appendix A and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapter for details.)

In addition, for the first half of FY 2000, OIG reported 1,278 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 205 convictions of individuals or entities that engaged in crimes against departmental programs, and 198 civil actions. (See sections entitled "Fraud and Abuse Administrative Sanctions" in the Health Care Financing Administration [HCFA] chapter and "Investigative Prosecutions and Receivables" in the General Oversight chapter.)

Included below are examples of some of OIG's most notable accomplishments for the 6-month period ending March 31, 2000.

FINANCIAL STATEMENT AUDIT

During FY 1999, the Department achieved an important milestone in financial accountability. In its fourth annual audit of the HHS financial statements, OIG issued an unqualified, or "clean," opinion for the first time. This opinion means that the Department successfully resolved previously reported opinion issues and that the FY 1999 statements reliably presented financial information.

However, OIG found that the Department's financial systems and reporting needed further improvement. An integrated accounting system was still lacking, and accounts were not reconciled and analyzed throughout the year to ensure the accuracy of reported amounts or to identify emerging problems. This deficiency and continuing problems in controls over Medicare accounts receivable and Medicare electronic data processing were reported as material weaknesses.

The OIG also issued its fourth report on the Medicare fee-for-service payment error rate. Based on a statistically valid sample, improper payments totaled an estimated \$13.5 billion,

or about 7.97 percent of the \$169.5 billion in FY 1999 processed fee-for-service payments. While this year's estimate is about \$1 billion higher than last year's, OIG cannot conclude that the current estimate is statistically different. This year's estimate is \$9.7 billion less than that for FY 1996, when OIG developed the first national error rate. (See pages 2, 3 and 66)

SIGNIFICANT INVESTIGATIVE RESULTS

Following are some of the major settlements that were finalized during this reporting period.

Dialysis Services Company

The Government reached a record-breaking Medicare fraud settlement with Fresenius Medical Care Holdings, Inc. (FMCH), the Nation's largest provider of kidney dialysis products and services. As a result of a joint investigation by OIG and multiple law enforcement agencies and an OIG audit, FMCH agreed to a global resolution under which three subsidiaries pled guilty, and the company agreed to pay \$486 million to resolve the criminal and civil aspects of the case. As part of the civil settlement agreement for credit balances, the company paid directly to HCFA \$11 million for overpayments which were previously reported to the fiscal intermediaries but never recouped. The alleged misconduct involved illegal kickback activity, submission of false claims for dialysis-related nutrition therapy services, improper billing for laboratory services and false reporting of credit balances. This misconduct was engaged in by National Medical Care, a nationwide dialysis company, and various of its subsidiaries prior to a 1996 merger with FMCH. As part of the settlement, the company also entered into the most comprehensive corporate integrity agreement ever imposed by OIG. (See page 33)

Nursing Home Chain

In the largest settlement ever reached in a nursing home case investigated by OIG, Beverly Enterprises, Inc. (Beverly), the Nation's largest nursing home chain agreed to pay the Government \$175 million to resolve criminal and civil issues and entered into a corporate integrity agreement with OIG. This multimillion dollar global settlement resolved allegations that the nursing home chain engaged in a nationwide scheme to defraud Medicare of approximately \$400 million by inflating nursing costs charged to the program. Under the terms of the settlement, Beverly will pay \$170 million in a civil settlement, based on a limited ability to pay. A company subsidiary, which also pled guilty to criminal charges, will pay \$5 million in criminal fines and divest itself of 10 nursing homes. (See page 20)

Former Medicare Fiscal Intermediary

Anthem Blue Cross and Blue Shield of Connecticut (Anthem), Connecticut's former Medicare fiscal intermediary, agreed to pay the Government \$74.3 million to resolve allegations of wrongdoing by its predecessor corporation. The company allegedly falsified hospital cost reports to meet Government performance standards as a Medicare fiscal intermediary. The company's misconduct led several Connecticut hospitals to improperly receive Medicare overpayments and enabled the company to obtain a better performance evaluation from the Health Care Financing Administration (HCFA) than it would have

otherwise received. This settlement represents the largest civil settlement in a health care fraud case in the State and the second largest Medicare contractor settlement nationwide. As part of the settlement, the company, which is no longer an intermediary, agreed to the imposition of a corporate integrity agreement for 5 years for its Medicare+Choice health maintenance organization contract, which it still operates. (See page 34)

FRAUD PREVENTION

The OIG has also continued to expand activities designed not just to uncover existing fraud and abuse, but to prevent it.

Safe Harbor Regulations

The OIG's efforts to focus on preventing health care fraud includes guidance to industry on the propriety of health care transactions. In this reporting period, OIG published two significant final regulations creating 10 new safe harbors to the Federal anti-kickback statute. The new safe harbors address a variety of payment arrangements, including certain joint venture and recruitment arrangements in underserved urban and rural areas, investments in ambulatory surgical centers and managed care or "risk sharing" arrangements. The final regulations also clarified certain aspects of the existing safe harbors. (See page 15)

Compliance Guidance

A key element of OIG's prevention efforts has been the development of compliance program guidance to encourage and assist the health care industry to fight fraud and abuse. The guidance, developed in conjunction with the provider community, identifies steps that health providers may voluntarily take to improve adherence to Medicare and Medicaid rules. During this reporting period, OIG developed and released final compliance guidance for Medicare + Choice organizations that offer coordinated care plans and nursing homes. (See page 36)

PATIENT PROTECTION

Patient protection continued to be a focus of OIG audit, inspection and investigation activity this reporting period.

Adverse Drug Reactions

To ensure a prompt and appropriate regulatory response to reports of adverse drug reactions (ADRs), OIG proposed that, among other actions, FDA more effectively coordinate its post-market drug risk assessment and review divisions; establish a quality control system that ensures that potentially serious ADRs are not overlooked; and coordinate with HCFA to require hospitals to report all serious ADRs as a condition of participating in Medicare and Medicaid. (See page 50)

Infusion Therapy Services Provided in Skilled Nursing Facilities

The OIG found that because suppliers provided skilled nursing facilities (SNFs) with unnecessary, overpriced and incorrectly billed infusion therapy services, patients were

placed at risk, SNFs were overpaid by Medicare and infusion therapy costs were incorrectly classified on SNF cost reports. The OIG recommended that before HCFA refines or updates the SNF prospective payment system rates, it consider the impact of the overpayments for infusion therapy services; identify and recover such overpayments to SNFs; and direct its contractors to perform medical reviews to ensure that patients are receiving the appropriate levels of infusion therapy. (See page 9)

External Review of Hospital Quality

The OIG discussed State initiatives aimed at overseeing hospital quality in a follow-up study to a recent series of reports that assessed the roles played by HCFA and the Joint Commission on Accreditation of Healthcare Organizations in overseeing hospitals that participate in Medicare. (See page 4)

MANAGED CARE

In this semiannual period, the OIG has released a number of studies that have looked at various aspects of managed care.

Capitation Payments

The OIG found that the base year rates used to determine Medicare capitation payments to managed care organizations (MCOs) were overstated by 4.2 percent, and would cause capitation payment excesses totaling \$11.3 billion and \$34.3 billion over the next 5 and the next 10 years, respectively. (See page 5)

Federal/State Medicaid Partnership

As part of its partnership work with the Florida Auditor General's Office, OIG found that beneficiaries dually eligible for Medicare and Medicaid received Medicaid medical services and drugs paid for by the State Medicaid fee-for-service program that should have been covered by a Medicare MCO. The OIG recommended that the State recover \$4.7 million in unallowable payments from one MCO, and identify the liability of each of the other 50 MCOs in the statistical samples reviewed; OIG estimated that these liabilities total \$11.2 million. (See page 44)

Medicaid Mental Health Programs

Three related reports reviewed mental health programs in seven States that were among the first to convert from fee-for service to mandatory managed care. This allowed those States to offer more specialized and creative outpatient services, and it was found that overall use of mental health services increased. However, the impact on beneficiaries was not quantified due to lack of outcome measurement systems. State respondents reported reduced costs, but OIG found that savings from managed care operations were not always used to improve mental health services. (See page 45)

HOME HEALTH

Medicare home health services were revisited by OIG auditors, inspectors and investigators during this reporting period.

Home Health Services in Four States: A Follow-Up

In this follow-up to an earlier review, OIG found that the rate of improper or highly questionable Medicare home health services fell from 40 percent for the 15-month period ending March 31, 1996 to 19 percent for the 9-month period ending September 30, 1998. The OIG recommended that HCFA, among other actions, consider the 19 percent error rate before adjusting the current home health agency (HHA) payments, and account for any error payments used in calculating the current HHA prospective payment system rates before adjusting the rates. (See page 16)

Home Health Agency Fraud

The OIG continued to address home health agency (HHA) fraud through the sponsorship of a home health fraud conference and through the investigation of home health fraud itself. At the conference held in December 1999, representatives of Government agencies and private insurers came together to discuss the successful investigation and prosecution of home health fraud cases. This information sharing session provided attendees with the opportunity to compare HHA cases and the strategies used to work them. In addition to hosting this conference, OIG also achieved significant results in investigating home health fraud this period. One major example of OIG's success in this area was its investigation and audit of what was once South Florida's highest paid HHA Medicare provider. Initiated as part of Operation Restore Trust, OIG's efforts in this case resulted in the indictment of 26 people in December 1998 and an information filed against an additional individual in October 1999. Those charged participated in a complex Medicare fraud scheme in connection with the HHA. During this reporting period, four of the 26 individuals indicted, and the additional individual charged in the information, were sentenced for their part in causing the HHA to allegedly submit over \$45 million in false claims to Medicare. (See page 17)

Beneficiary Access

In an OIG review of the impact of the new interim payment system on Medicare beneficiaries' access to home health services, 85 percent of discharge planners reported that Medicare patients were able to obtain home health care when needed; 83 percent said HHAs either never or infrequently refused to take Medicare patients; and 75 percent indicated they needed to contact only one HHA on average to obtain care for their patients. However, OIG noted that 50 percent of planners reported that certain subgroups of patients had become more difficult to place, and 25 percent expressed concern that some Medicare patients might not be receiving either the length or adequacy of care they need. (See page 15)

CHILD SUPPORT ENFORCEMENT

In addition to its audit and inspection work in this area, OIG has made the detection and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG has worked with the Office of Child Support Enforcement (OCSE) and other Federal, State and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations. The OIG has opened 966 investigations of child support cases nationwide since

1995, which have resulted in 219 convictions and court-ordered restitution and settlements of over \$13.8 million.

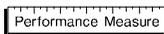
Investigative Task Forces

In 1998, OIG and OCSE initiated Project Save Our Children, a criminal child support initiative made up of multiagency, multijurisdictional investigative task forces. The task forces bring together enforcement units from different States within certain geographical regions. Based on the success of the initial task forces in the Midwest and Mid-Atlantic regions, three additional task forces were opened in the Southwest, the Northeast and the West Coast in 1999. The task forces are designed to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources; their goal is to create streamlined systems of referral, investigation and prosecution that will bring to justice the most egregious offenders. (See page 57)

Paternity Establishment

The OIG issued two reports on paternity establishment during this period. In one, OIG identified some promising strategies to surmount barriers to genetic testing of putative parents. In the second, OIG made recommendations to OCSE designed to promote greater collaboration between local child support agencies and State vital records agencies. (See pages 56)

OIG WORK IN PERFORMANCE MEASUREMENT

In order to identify work done in the area of performance measurement, OIG has labeled some items throughout this report as **performance measures** with the symbol . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the audits, inspections and investigations identified with the performance measure symbol offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals. These proposals are provided to management for their consideration as they develop their performance measures. (See Appendix F)

INTERNET ADDRESS

This semiannual report and other OIG materials may be accessed on the Internet at the following address: <http://www.hhs.gov/oig>

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**Health Care
Financing
Administration**

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons, and is financed by the Federal Hospital Insurance Trust Fund. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services, and is financed by participants and general revenues.

The Medicaid program provides grants to States for medical care for certain low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for Supplemental Security Income or the former Aid to Families with Dependent Children program. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The State Children's Health Insurance Program (SCHIP), created under the new title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. The SCHIP program is a partnership between the Federal and State governments in which States may choose to expand their Medicaid programs, design new child health insurance programs or create a combination of both.

The Office of Inspector General (OIG) has devoted significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have often led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse. They also have helped ensure the cost-effective delivery of health care, improved the quality of health care and reduced the potential for fraud, waste and abuse.

Over the years, OIG findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services; regional consolidation of claims processing for durable medical equipment (DME); establishment of fraud units at Medicare contractors; prohibition on Medicare payment for physician self-referrals; and new payment methodologies for graduate medical education.

The OIG's documentation of excessive payments led to recent statutory changes in the way and/or the amount Medicare reimburses rural health clinics, skilled nursing facilities, home health agencies (HHAs), hospices, ambulance services, oxygen suppliers, clinical laboratories, suppliers of certain Medicare-covered drugs and biologicals, teaching hospitals for indirect medical education costs and the States for Medicaid disproportionate share payments. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of medical equipment and of services provided by HHAs; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

The OIG also audits HCFA's financial statements, which account for more than 84 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG has assessed compliance with Medicare laws and regulations and the adequacy of internal controls.

Improper Fiscal Year 1999 Medicare Fee-for-Service Payments



The OIG reports that improper payments under Medicare's fee-for-service (FFS) system totaled an estimated \$13.5 billion during Fiscal Year (FY) 1999. This year's estimate is about \$1 billion more than last year's estimate and is \$9.7 billion less than that for FY 1996, when OIG developed the first national error rate. While this year's estimate is higher than last year's, OIG cannot conclude that the current error rate is statistically different.

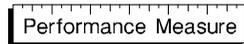
The OIG developed the estimate of improper payments with the support of medical experts who together reviewed a comprehensive, statistically valid sample of Medicare fee-for-service claims expenditures and supporting medical records to determine the accuracy and legitimacy of the claims.

The OIG believes that since the first error rate of 1996, HCFA has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, it clearly shows that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly and documented properly. For both FYs 1998 and 1999, OIG estimated that over 90 percent of the fee-for-service payments met Medicare reimbursement requirements.

While OIG's 4-year analysis indicates continuing progress in reducing improper payments, there are indicators that documentation errors and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for over 70

percent of the total improper payments over the 4 years. The HCFA needs to sustain its efforts to maintain progress in reducing these improper payments. (CIN: A-17-99-01999)

Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1999



In its audit report on HCFA's FY 1999 financial statements, OIG issued an unqualified opinion of the statements, namely that they present fairly HCFA's financial position, its net costs, changes in net position, budgetary resources and reconciliation of net costs to budgetary obligations as of September 30, 1999, in conformance with generally accepted accounting principles. However, the audit found that material weaknesses continue in financial systems and reporting, Medicare accounts receivable and electronic data processing controls.

The OIG again found that the absence of a fully integrated financial management system impairs HCFA's ability to accumulate, reconcile, analyze and report financial information in a timely manner. During FY 1999, this contributed to not promptly identifying an overfunding and underfunding of the trust fund accounts and a net loss of interest earnings.

The HCFA initiated a major effort in FY 1999 to validate and document accounts receivable, which resulted in HCFA being able to report that the receivables balance was fairly presented as of the year's end. However, OIG again found that HCFA and the Medicare contractors still do not have adequate internal controls to ensure that future receivables will be properly reflected in their financial reports.

Further, OIG again found that weaknesses continue in EDP general controls at the HCFA central office and the Medicare contractors, as well as in application controls at the contractors' shared systems.

The HCFA concurred with OIG's recommendations and is in the process of taking corrective action. (CIN: A-17-00-00500).

Hospital Ownership of Physician Practices

As part of the changing health care market, hospitals, as well as other entities, have been purchasing physician practices. While hospitals have historically operated outpatient clinics located on their campuses, many of the newly acquired practices are not located on the hospital grounds. The location and operation of these clinics raise questions regarding the payment methods Medicare should use for the service provided by these purchased practices. It is HCFA's policy that a hospital may treat an acquired physician practice as either provider-based or free-standing. The hospital's decision on how to treat the practice will affect the amount of payment received by the hospital for physician services rendered in the practice.

Based on its review, OIG estimated that 62 percent of for-profit and not-for-profit general, short-term hospitals purchased or owned a physician practice. The OIG also found that fiscal intermediaries (FIs) were aware of this ownership only about 50 percent of the time and that this lack of knowledge resulted in a fiscal vulnerability to the Medicare program. Moreover, provider-based status increased beneficiary coinsurance costs with questionable benefit to Medicare and its beneficiaries.

The OIG recommended that HCFA change its policy to eliminate the provider-based designation for hospital owned physician practices; require hospitals to report all purchases of physician practices or clinics and declare how the costs associated with the operation of these entities are handled in hospital cost reports; and seek legislation to sanction hospitals for failure to report the ownership of physician practices. The HCFA concurred with the latter two recommendations, but disagreed with the first. (OEI-05-98-00110)

Analysis of Readmissions Under Medicare Prospective Payment System

The OIG analyzed Medicare PPS claims for Calendar Years (CYs) 1996 and 1997 involving the same-day discharge and readmission of beneficiaries from and to the same PPS hospitals. The OIG analyzed the distribution of readmissions by provider, State, diagnosis related group (DRG) discharge code and beneficiary level. In its analysis, OIG noted that a number of beneficiaries had been discharged and readmitted repeatedly. The OIG also noted that a substantial number of readmitted beneficiaries had the same DRG code during their first and second stays.

Based on its analysis, OIG expressed concerns about the same-day readmission rate, and what it intimates about the quality of care delivered and the accuracy of billing statements related to such care. The OIG recommended that HCFA make the data in this report available to its contracted peer review organizations for their use in focusing their reviews on the medical care provided beneficiaries. The OIG also recommended that HCFA review hospitals with higher than average readmission rates as well as the claims of beneficiaries who have been multiply discharged and readmitted, or been multiply discharged and readmitted under the same DRG code. In response to the draft report, HCFA concurred with OIG's recommendations. (CIN: A-14-99-00401)

External Review of Hospital Quality: State Initiatives

Performance Measure

This inspection discusses State initiatives aimed at overseeing hospital quality. It is a follow-up to a recent series of reports that assessed the roles of HCFA and the Joint Commission on Accreditation of Healthcare Organizations in overseeing hospitals that participate in Medicare. In this report, OIG provides snapshots of six such initiatives in three categories: standardized performance measures, on-site surveys and public disclosure

of hospital performance on the Internet. The State initiatives presented show that States can draw on their own authorities and resources to add a measure of public protection not provided by either HCFA or the Joint Commission. States contribute a valuable complement to the existing, national approaches to external review. In addition, States can serve as important catalysts for continued national efforts aimed at improving hospital oversight. In fact, these States' initiatives and others that are underway can be instructive to HCFA and the Joint Commission, as well as to other States. (OEI-01-97-00054)

Medicare+Choice Health Maintenance Organization Extra Benefits: Beneficiary Perspectives

In this inspection, OIG looked at the influence of extra benefits on beneficiaries' decisions to join Medicare+Choice health maintenance organizations (HMOs). The OIG determined that lower costs, more so than extra benefits, are the main reason for joining an HMO. Once enrolled in an HMO, Medicare beneficiaries value prescription drugs, regular physicals and vision benefits the most. The prescription drug benefit is least likely to meet their expectations. While, enrollees have a good understanding of their coverage for regular physicals, their understanding of other benefits is not as high. The OIG also found that the HMO marketing material descriptions of extra benefits coverage were generally easy to understand, but varied greatly. Also, there was potential for confusion in some of the materials.

The OIG recommended that HCFA develop mechanisms to assure comparability of Medicare+Choice HMO plan costs and benefits. The HCFA has developed a standard format for plan benefit summaries which were used by plans in the November 1999 open enrollment period, and OIG encourages the completion of this task. (OEI-02-99-00030)

Overpayments to Managed Care Organizations Due to Overstated Capitation Rates

The Balanced Budget Act (BBA) of 1997 established the Medicare+Choice program and directed HCFA to use 1997 standardized county rates as the basis for all future capitation payments to managed care organizations (MCOs). Information from HCFA showed that these rates were based on actuarial estimates and, when compared with actual costs incurred, were overstated by 4.2 percent. Applying this percent to Congressional Budget Office projections of further Medicare payments to MCOs, OIG concluded that the inflated payment rates will result in Medicare overpayments totaling \$11.3 billion over the next 5 years and \$34.3 billion over the next 10 years.

The OIG recommended that HCFA seek legislation to correct the overstated base year rates. The HCFA replied that the President's Medicare reform package included a proposal to change the methodology used to set payment rates for MCOs, eliminating use of the overstated base year rates. However, this reform package has not been passed, and current

legislation continues the payment methodology with an increase in payments as well as a delay in any competitive bidding demonstration projects. Therefore, OIG continues to recommend that HCFA seek a legislative correction. (CIN: A-05-99-00025)

Adjusted Community Rate Proposals for Risk-Based Managed Care Organizations

The adjusted community rate (ACR) process is designed for MCOs to present to HCFA their estimates of the funds needed to cover the costs (both medical and administrative) of providing the Medicare package of services to enrolled beneficiaries. In previous audits, OIG concluded that the methodology allowing MCOs to apportion administrative costs to Medicare was flawed and that Medicare covered a disproportionate amount of these costs. As part of its continuing reviews of these areas, OIG reported on the administrative costs included in the ACR proposals of numerous MCOs during this period.

A. Administrative Cost Component of Nine Managed Care Rate Proposals

The OIG determined that the HCFA methodology used to develop adjusted community rate proposals results in Medicare paying a disproportionate share of managed care administrative costs. Of the nine MCOs reviewed, five exceeded the estimated administrative costs included in their rate proposals by an average of 100 percent; the total estimated and actual administrative costs of the five MCOs -- \$231.9 million and \$115.7 million, respectively -- were at variance by \$116.2 million. Further, \$66.3 million in costs claimed by all nine MCOs would have been recommended for disallowance had the MCOs been required to follow Medicare's general principle of paying only reasonable costs.

The OIG recommended that HCFA pursue legislation to extend this Medicare general principle to MCO administrative costs. Also, OIG recommended that HCFA consider publishing the administrative cost rates of all MCOs participating in the Medicare program as a means of helping Medicare beneficiaries become better educated consumers of health care services. (CIN: A-03-98-00046).

B. Administrative Costs in Rate Proposals Are Inconsistent among Managed Care Organizations

The OIG found that the administrative costs included in the adjusted community rate proposals submitted by 232 risk-based MCOs for each year from 1996 through 1999 contained significant disparities among plans. In 1999, for example, the amounts allocated by MCOs for administrative costs ranged from a high of 32 percent to a low of 3 percent; this disparity was noted in each year of OIG's review regardless of plan model or tax status (such as group, individual practice association or staff, or profit or nonprofit). In contrast to other areas of Medicare, HCFA has not established a ceiling on what an MCO can reasonably allocate for administrative costs on its rate proposals.

The OIG recommended that HCFA establish such a ceiling, noting that \$1 billion in additional benefits or reduced payments (such as deductibles and/or coinsurance) might have flowed to Medicare beneficiaries had a 15 percent ceiling been in effect in 1998. While HCFA agreed that rate proposals should be more thoroughly analyzed, it disagreed with OIG's recommendation for a ceiling on administrative costs, claiming that it might discourage MCOs from developing cost efficient plans. (CIN: A-14-98-00210)

Fee-for-Service Payments for Medicare Beneficiaries Enrolled in Managed Care Risk Plans

In a review involving beneficiaries in Colorado, Florida, Missouri and Pennsylvania who were enrolled in a risk plan for at least one month during CYs 1995 through 1997, OIG found that the Medicare FIs improperly paid \$2.3 million for FFS Part A services. Because Medicare paid capitation payments to MCOs to provide all medically necessary services for these beneficiaries, payments under FFS were duplicate payments. The \$2.3 million in duplicate payments consisted of 733 claims in the four States. Further, OIG believes that improper payments are being made nationally since procedures to detect and prevent these duplicate payments have not been implemented. The amount of duplicate payments could be significant when considering the MCO risk plan enrollees in the States not reviewed and the fact that Medicare FFS Part B services were not reviewed. Compounding the problem is the impact these duplicate payments have on future MCO payments. The BBA of 1997 links the 1998 and future MCO capitation rates to the 1997 Medicare FFS expenditures.

The OIG recommended that HCFA strengthen procedures to prevent and detect duplicate payments where the MCO has payment responsibility; identify and recoup all duplicate FFS payments made under Medicare Parts A and B for MCO enrollees, including the \$2.3 million identified in this study; and consider developing a legislative proposal to adjust the MCO capitation rates for the duplicate payments that were included in the managed care rate calculation methodology. The HCFA agreed with the first two recommendations, but did not believe that it was advisable at this time to undertake the third recommendation. (CIN: A-07-97-01247)

Payments to Medicare Managed Care Risk Plans for Deceased Beneficiaries

This final report points out that HCFA paid \$3.1 million to MCOs for beneficiaries who were deceased. Although HCFA had recouped \$1.2 million of the improper payments, \$1.9 million remained outstanding due to HCFA being unaware of all the deaths and its lack of action to collect some identified overpayments.

The OIG recommended that HCFA recover the \$1.9 million erroneously paid and make immediate system corrections to prevent continuing annual overpayments of \$250,000 to MCOs for the identified deceased beneficiaries. After issuance of the draft report to HCFA,

OIG continued work in this area and identified an additional \$1.1 million in payments for beneficiaries who died subsequent to the cut-off date of the initial review. The OIG proposed that HCFA also take action to recover these additional overpayments. The HCFA has agreed to recoup all the monies derived from the disenrollment date to the time of the corrected record, even if that payment adjustment exceeds 36 months. The managed care system was modified in 1998 and again in November 1999 to permanently correct the problem. (CIN: A-07-99-01283)

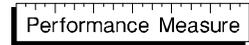
Medicare Managed Care: Goals of *National Marketing Guide*



This first of two related inspections looked at whether Medicare's *National Marketing Guide* for managed care met its established goals in 1998. The OIG found that the goals -- which were to expedite the marketing material review process; reduce resubmissions of material; ensure uniform review across the Nation; and, most important, provide beneficiaries with accurate and consumer-friendly marketing materials to help them make informed health care choices -- were not completely met. However, marketing guidelines were clearer than they had been, and creating and reviewing marketing materials was easier. Two operational elements of the *National Marketing Guide* were not well understood or applied uniformly: the Use and File system (which allows managed care plans that meet certain criteria to distribute sales materials without prior approval from HCFA) and checklists (which help ensure that all plan enrollees receive important information). The OIG also found that marketing material reviews were not tracked consistently across HCFA regions.

The OIG made a number of recommendations to address the issues identified. The HCFA concurred with the recommendations and is already beginning to implement some of them. (OEI-03-98-00270)

Medicare Managed Care: 1998 Marketing Materials



This second report looked at whether marketing materials of managed care plans met Federal guidelines in the first year after implementation of Medicare's *National Marketing Guide* (1998). The OIG found that few marketing materials, which had been approved by reviewers in HCFA, were in full compliance with the *National Marketing Guide*. Also, nearly half the materials were not consumer friendly.

The OIG recommended that HCFA update the *National Marketing Guide* to include clarification of requirements; ensure that model materials are accurate and easy to read; mandate use of standard member materials; develop standard review instruments; establish a quality control system; track marketing materials reviews consistently and uniformly; conduct meetings with noncomplying health plans; and provide training for HCFA reviewers and managed care plans. The HCFA concurred with OIG's recommendations and is already beginning to implement some of them. (OEI-03-98-00271)

Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective

Performance Measure

The BBA of 1997 changed skilled nursing facility (SNF) reimbursement to a prospective payment system (PPS). As a result of concerns about the effect of the new system, HCFA requested that OIG assess whether the PPS is causing access problems for Medicare beneficiaries. In an inspection report issued in August 1999, OIG concluded that no serious problems in placing Medicare patients in nursing homes were apparent.

As a supplement to that study, OIG interviewed a random sample of 57 nursing home administrators and personnel responsible for assessing residents' needs. The OIG determined that few nursing home administrators believed that access to nursing home care had become a problem because of the PPS. However, most administrators stated that they scrutinized patients' medical status to a greater extent than prior to implementation of the PPS. While administrators said that they preferred to admit certain types of patients, Medicare data showed no change in nursing home placements. Over 80 percent of administrators supported the overall concept of the PPS, though they stressed the need to revise some of the current reimbursement rates.

The findings in OIG's two reports indicated that while nursing homes had changed their admission practices in response to the PPS, access to skilled nursing care had not become a problem in many areas, most likely because beds were available. However, since these practice changes may affect beneficiaries with certain medical conditions and may also affect nursing homes' reimbursement, the Department must remain vigilant to potential problems. The HCFA generally agreed with OIG's findings and conclusion. (OEI-02-99-00401)

Infusion Therapy Services Provided in Skilled Nursing Facilities

In a review of three infusion suppliers for the period 1995 through 1998, OIG determined that they provided Medicare-reimbursed SNFs with infusion therapy services that were excessively priced and unnecessary. In addition, the three infusion suppliers billed certain infusion services incorrectly, causing those costs to be misclassified on the SNFs' cost reports. This occurred because the reimbursement system was vulnerable to abusive billing schemes. As a result, patients were placed at undue risk, Medicare overpaid the SNFs and the overpayments may have been included in the base year costs used to establish the PPS rates.

The OIG recommended that HCFA consider the impact of improper payments for infusion therapy services before making any refinements or updates to the SNF PPS rates; identify and recover overpayments made to SNFs for unnecessary and overpriced infusion services prior to the adoption of PPS; and direct its contractors to perform medical reviews of

selected SNF patients to ensure that patients are receiving appropriate levels of infusion therapy. The HCFA generally agreed with OIG's recommendations. (CIN: A-06-99-00058)

Major Hospital Initiatives

The OIG has launched five national projects involving civil actions at hospitals that were falsely billing the Medicare program. Three of the five grew from OIG hospital audits that identified irregularities in Medicare billing practices.

A. Physicians at Teaching Hospitals

The OIG has undertaken a nationwide initiative to review compliance with the rules governing reimbursement to physicians at teaching hospitals (also known as the PATH initiative). The specific objectives of the PATH audit initiative are to verify compliance with the Medicare rules governing payment for physician services provided by residents and teaching physicians, and to ensure that all claims for physician services accurately reflect the level of service provided to the patient.

Medicare pays the costs of training residents through the graduate medical education (GME) program. Medicare also pays an additional amount in recognition of the additional costs associated with training residents (also known as indirect medical education or IME). These payments can total over \$100,000 per resident per year. Medicare paid approximately \$8 billion to teaching hospitals in 1998 for the costs of training residents. The Medicare payments described above include payments to teaching physicians for their role in supervising residents.

The fundamental tenet of the PATH initiative is that in order to receive reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided that service or have been present when the resident furnished the care. Physicians claiming reimbursement for services performed by the resident alone are making a duplicate claim -- one that has already been paid for under Part A through the GME and IME payments.

The PATH audits also include a review of Part B claims information and medical records to determine if the teaching physician claimed the appropriate reimbursement for the level of service provided. The Medicare billing system's vulnerability to upcoding is a longstanding concern at OIG. The PATH reviews are designed to detect patterns or practices of upcoding, resulting in unwarranted loss to the Medicare Trust Fund.

In sum, the PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, six institutions have entered into settlements with the Federal Government to resolve potential False Claims Act liability related to improper claims for Part B physician services submitted in the teaching setting. These settlements

have resulted in the Government's recovery of over \$75 million. As a condition of settlement, these institutions have also implemented compliance programs to prevent and detect future improper claims. Reviews completed at four other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly, and reviews at two institutions resulted in administrative overpayment settlements with the carriers.

Separately, four investigations not part of the PATH initiative, but which included billings for teaching physicians, concluded in False Claims Act settlements totaling over \$31 million. In all of these cases, the providers also entered into corporate integrity agreements with OIG.

To determine whether, and to what extent, problems similar to those noted above were present at other teaching institutions throughout the Country, the PATH project was expanded into a national initiative, but limited to those institutions that received clear guidance before December 30, 1992 from the Medicare Part B carriers communicating the applicable HCFA reimbursement standards. As an alternative to OIG auditors conducting the audits, these providers are given the opportunity to conduct self-audits by contracting with an independent third party for a review of their Medicare billing practices, with Government oversight, and to report the audit results to OIG.

B. Diagnosis Related Group Three-Day Window Project

In 1995, OIG and the Department of Justice (DOJ) launched a national project to recover overpayments made to hospitals as a result of claims submitted for nonphysician outpatient services that were already included in the hospitals' inpatient payment under the PPS. Hospitals that submit claims for the outpatient service in addition to the inpatient admission are, in effect, double billing for the outpatient services. In addition, the project seeks to recover for those services rendered to beneficiaries during the inpatient admission that should be included in the DRG, but are separately charged. A prevalent pattern of abuse was identified through repeated OIG audits of hospital claims for inpatient services under PPS. Prior to the inception of this project, OIG had issued four reports to HCFA identifying approximately \$115.1 million in Medicare overpayments to hospitals caused by these improper billings.

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. The project is primarily coordinated by the U.S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,672 hospitals and over \$71.3 million had been recovered.

One of the most important aspects of this project is the stipulation in each settlement agreement that each hospital will assure compliance with proper billing for inpatient and outpatient services. Such compliance measures are designed to prevent and detect erroneous

billing. It is hoped that the deterrent effect of possible civil actions, along with promised compliance, will remove this source of improper claims.

C. Hospital Outpatient Laboratory Project

The OIG, DOJ and multiple States have joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. A project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare FI proved so successful, United States Attorneys' Offices in other States began their own investigations as part of an expanded effort. This project involves the recovery of multiple damages, when appropriate, for improper and excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abuses stem from the improper unbundling and double billing of laboratory tests, and, in certain cases, the billing for certain tests that are not medically necessary. The investigations have also shown numerous instances of billing for hematology complete blood count (CBC) additional indices that were not ordered by physicians and were not medically necessary.

Clinical laboratory services were particularly vulnerable to these abuses because of the multiple number of tests ordered at one time and the capability of automated equipment to run numerous tests from one sample of blood at a low cost. Under Medicare guidelines, the hospitals were required to bill certain groupings of blood chemistry tests using a bundled code. The Medicare payment for blood chemistry panels is significantly less than the payments for each test billed separately.

The OIG and DOJ, and in some districts, authorities from other Federal programs such as TRICARE (the health care benefits program for current and former military employees) and Federal Employees Health Benefits Program (FEHBP), are working together on the national project to provide targeting data to the United States Attorneys' offices interested in pursuing this recovery initiative in their districts. The OIG also collaborated with DOJ to produce a model settlement agreement that includes compliance measures, which has been disseminated to all participating districts throughout the United States.

Thus far, 249 hospitals have entered settlements in the Hospital Outpatient Laboratory Project, with settlements totaling more than \$56 million. More hospitals are expected to settle in the near future.

D. PPS Patient Transfer Project

Another OIG/DOJ nationwide initiative is focused on improper payments to hospitals for patient transfers between two PPS hospitals. Under Medicare reimbursement rules, the hospital transferring a patient is to receive a per diem payment based on the length of stay and the DRG for the case, but no more than the full DRG payment amount, and the hospital receiving the transferred patient is to be paid a diagnosis-related payment based on the DRG for the case.

Since 1986, however, OIG has found that many transferring hospitals inappropriately claim full diagnosis-related payment rather than the per diem payment. The HCFA has already acted on OIG's first report, which identified \$227 million in recoveries and savings. The OIG's second report, issued in November 1996, and a more recent computer analysis of claims disclosed additional overpayments of approximately \$202 million. Currently, OIG is working with U.S. Attorneys' offices nationwide, along with HCFA, to address this continuing problem.

E. Pneumonia Upcoding Project

Medicare inpatient hospital stays are reimbursed based on the DRG that is assigned to the patient's stay. The determination of the appropriate DRG for a particular case depends upon the hospital's assignment of diagnosis code(s) and procedure codes from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) to the inpatient stay. Most pneumonia cases are grouped into one of four DRGs, one of which results in significantly higher payment to the hospital than do the others. Most pneumonia cases are grouped into the lower-paying DRGs. The OIG has found that a small percentage of hospitals across the country have assigned a disproportionate number of pneumonia cases diagnosis codes that result in an admission being assigned the higher paying DRG. Review of the medical records has demonstrated that most of the cases assigned these specific diagnosis codes at these hospitals should have been assigned a diagnosis code that would result in assignment of a lower-paying DRG.

The OIG is currently investigating the coding for pneumonia upcoding at over 100 hospitals. To date, 16 hospitals have settled their liability for such coding by paying over \$19.7 million and agreeing to corporate integrity requirements.

Other Hospital Investigations

The following cases are significant examples of other hospital-related cases resolved during this period which were not part of the special projects described above:

- A New Jersey hospital agreed to pay the Government \$2.1 million to resolve its civil liability for submitting improper Medicare claims during the period 1992 through 1997. The hospital wrongfully submitted claims for inpatient hospital stays for patients who received outpatient services. The hospital received greater reimbursement for the inpatient claims than it would have received if it had billed for the outpatient services actually provided. As part of the settlement, the hospital also agreed to enter into a 5-year corporate integrity agreement with OIG to ensure compliance with the requirements of Federal health care programs. The corporate integrity agreement includes auditing and training provisions designed to specifically address the submission of claims for outpatient services.

- Four Ohio hospitals agreed to pay the Government a total of \$530,000 to settle allegations of submitting improper claims to Medicare. The hospitals improperly billed Medicare for self-administered drugs (SADs) provided in an outpatient setting. According to program laws and regulations, Medicare generally does not pay for SADs provided to outpatients. Rather, Medicare Part B pays for hospital services and supplies provided incident to a physician's services to outpatients, including drugs and biologicals that cannot be self-administered, with certain exceptions. These settlements are part of a mini-project pursued by the United States Attorney's Office for the Northern District of Ohio involving district hospitals and this billing issue. In these four cases, the providers voluntarily self-disclosed the issue to the United States Attorney's Office and entered into comprehensive corporate integrity agreements with OIG.
- The chief financial officer of a health care corporation's Florida division, and later the chief executive officer of the corporation's Florida group, was sentenced to 2 years and 9 months imprisonment, 3 years supervised release and payment of a \$10,000 fine. A stay of restitution of up to \$1.68 million was also granted until a related civil case is resolved. The corporate officer was convicted of conspiracy and fraud involving Federal health care programs. He and three others were indicted for causing the filing of various cost reports in a manner which would reimburse a Florida hospital substantially more than it was entitled to under the program. The claims involved capital versus noncapital interest expenses for loans obtained in the 1980's when the hospital was under different ownership. Based upon the filings of the cost reports, with interest expense categorized as capital rather than administrative and general, the Medicare, Medicaid and Civilian Health and Medical Plan of the Uniformed Services (now TRICARE) programs paid false claims of over \$3 million.
- A New York hospital agreed to pay the Government \$137,000 to resolve its civil liability under the False Claims Act. The alleged misconduct involved claims submitted by the hospital to Medicare Part B for reimbursement for unallowable ancillary pharmaceutical supplies provided. When a beneficiary has exhausted the 90-day inpatient hospital service coverage per benefit period and the 60 lifetime reserve days coverage, the beneficiary may, under certain circumstances, be eligible for payment of ancillary services under Part B; the Part B pharmacy ancillary benefit is limited to a few drugs, primarily immunological drugs. Between 1990 and 1995, the hospital billed Medicare Part B for certain ancillary pharmacy supplies not covered under the Part B ancillary benefit.

Industry Guidance

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from October 1, 1999 through March 31, 2000, OIG accepted 21 advisory opinion requests and issued 6 advisory opinions. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG has enlisted the help of the provider and beneficiary communities to prevent impropriety by soliciting proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute. The OIG received 17 timely-filed responses to the 1999 notice.

Where appropriate, OIG issues general guidance in the form of special fraud alerts describing practices that OIG has investigated and believes are fraudulent and special advisory bulletins articulating OIG's views on emerging practices or arrangements that potentially implicate OIG's fraud and abuse authorities. On November 10, 1999, OIG published in the Federal Register a special advisory bulletin on the Patient Anti-Dumping Statute (EMTALA) addressing the requirements of the statute and the obligations of hospitals to provide medical screenings for all patients seeking emergency services and to provide stabilizing medical treatment to all patients whose conditions warrant it. On February 23, 2000, OIG issued a special fraud alert entitled "Rental of Space in Physician Offices by Persons or Entities to Which Physicians Refer." The special fraud alert describes various space rental arrangements between physicians and entities to which they refer patients (such as suppliers of DME or mobile diagnostic equipment) that may raise concerns under the anti-kickback statute.

On November 19, 1999, OIG published in the Federal Register two significant regulations creating ten new safe harbors to the anti-kickback statute. Safe harbors protect from prosecution under the anti-kickback statute certain arrangements that squarely meet specified conditions. The first regulation was a final rule establishing eight new safe harbors and clarifying six of the original eleven safe harbors published in 1991. The new safe harbors address a variety of payment arrangements, including, but not limited to, certain arrangements in underserved urban and rural areas and investments in ambulatory surgical center joint ventures. The second regulation was an interim final rule with comment period for two new safe harbors in connection with the statutory exception for certain risk sharing arrangements created by HIPAA. The two new shared-risk safe harbors were promulgated pursuant to a negotiated rulemaking process.

Medicare Beneficiary Access to Home Health Agencies

Performance Measure

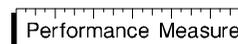
The BBA of 1997 changed the way Medicare pays for home health care. The law requires a payment change from a cost-based method to a PPS of fixed, predetermined rates for home

health services. Until this PPS is developed, however, HHAs are reimbursed under an interim payment system (IPS) which imposes payment limits on their services. The IPS was implemented on October 1, 1997 and will continue to be in place until the PPS begins on October 1, 2000.

At HCFA's request, OIG assessed how the IPS for HHAs is affecting Medicare beneficiaries' access to home health care for patients discharged from hospitals. The OIG's analysis was based on a survey of a national sample of 181 discharge planners and Medicare home health data. Eighty-five percent of discharge planners reported that Medicare patients were able to obtain home health care when they needed it; three-quarters needed to contact only one home health care agency on average to obtain care for their patients; and 83 percent said that home health care agencies either never or infrequently refused to take Medicare patients. Those discharge planners who indicated that they had problems in placing some home health care patients attributed it to Medicare eligibility requirements as well as the interim payment rate.

Planners noted that HHAs have changed their admissions practices over the past 2 years and over half reported that certain subgroups of patients had become more difficult to place. More than one quarter expressed concern that some Medicare patients may not be receiving the length of care or the adequacy of services they need. The HCFA was glad to note that the overwhelming majority of Medicare beneficiaries were receiving the home health care they needed, but requested OIG to continue its work in this area. (OEI-02-99-00530)

Medicare Home Health Services in California, Illinois, New York and Texas: A Follow-Up Review



The OIG's first review of home health services in four States with large Medicare expenditures -- California, Illinois, New York and Texas -- was released in 1997, and revealed that 40 percent of payments for such services were improper or inappropriate. The OIG's follow-up review, which covered the same four States and used FY 1998 home health data, revealed that the improper payment rate had fallen to 19 percent. An improper or inappropriate payment for a home health service is one that lacked a valid physician order, was provided to a beneficiary who was not homebound, could not be documented, or took place at a terminated HHA and for which service records could not be found.

The OIG recommended that HCFA revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days; consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current HHA payments; consider making an equitable adjustment to the proposed HHA PPS rates or update factors to take into account those payments that were included in the rate calculations; and instruct the FIs to collect the identified overpayments.

The HCFA was pleased with the progress made to reduce the payment errors in home health claims, concurred with OIG's concerns about inadequate physician involvement and agreed to collect the overpayments. However, HCFA did not agree to consider these findings in determining the prospective HHA payment rates. (CIN: A-04-99-01194)

Costs Claimed by Home Health Care Providers

The OIG conducted reviews of costs reported by various home health care providers to determine whether the services claimed met Medicare reimbursement guidelines. The reviews identified services that were unallowable for Medicare reimbursement because they lacked proper physician authorization, were not properly documented to show that a medical service was performed, were rendered to beneficiaries who were not homebound, were not reasonable and necessary or did not meet the intermittent criteria related to skilled nursing.

In separate reviews of three home health care providers, OIG identified a total of at least \$4.1 million in claims that did not meet the Medicare reimbursement guidelines. In each case, OIG recommended that HCFA have the intermediary recover the identified overpayments and ensure that corrective actions are effectively implemented. (CIN: A-02-97-01026; CIN: A-02-97-01034; CIN: A-04-98-01184)

Home Health Agency Fraud

Home health agencies are one of the fastest growing segments of the health care industry because they allow many patients to remain in their own homes at less expense than might be incurred at a hospital or other institution. The OIG has become aware of a number of fraudulent arrangements by which home health care providers, medical professionals and others associated with the operation of HHAs, inappropriately bill Medicare and Medicaid. The following cases represent some examples of improper activities related to the provision of home health care services:

- In the ongoing case against what was once South Florida's highest paid Medicare HHA provider, five individuals connected with the HHA were sentenced for their roles in the complex Medicare fraud scheme. Prior to its closure in 1994, the HHA received approximately \$42 million annually from Medicare. The HHA allegedly submitted over \$45 million in false claims. Four of the individuals sentenced this period were among the 26 people indicted in December 1998 on Medicare fraud related charges. These individuals were either directly involved with the HHA or its unlicensed or unapproved HHA subcontractors. The indictment charged racketeering, racketeering conspiracy, money laundering conspiracy and conspiracy to submit false claims. With these recent sentences, 24 of the 26 people originally indicted have now been sentenced. Also this period, a fifth individual was sentenced based on his guilty plea to an information

filed, charging him with conspiracy. This individual worked as the day-to-day manager of operations at a transcription company that provided nursing and home health aide progress notes to the Florida HHA and its subcontractors. The individual submitted invoices to the HHA which included deliberately inflated charges for technical services not provided. The HHA received Medicare reimbursement for the inflated costs by submitting them as overhead expenses on quarterly and annual cost reports filed with Medicare.

- A Federal judge in New York handed down life sentences to a woman and her son for their roles in the 1997 murder of the woman's former business partner and lover. Mother and son were convicted of murder conspiracy, murder-obstruction of justice, firearms conspiracy and use of a firearm. The son was also convicted of possession of a firearm with an obliterated serial number. In addition to murder-related charges, their sentences encompassed their guilty pleas to health care fraud-related charges and included an order to pay \$1.9 million in restitution to the New York State Medicaid program. As founder and executive director of an HHA fully funded by Medicaid, the woman devised and engaged in numerous schemes to defraud the program. When the woman's former business partner and lover became involved in a financial dispute with her and threatened to report her schemes to the Government, she and her son conspired his murder, and the son executed the man. In addition, a physician was sentenced for his involvement in these schemes to defraud Medicaid. The physician was sentenced to 5 months in a community confinement facility, 5 months home detention and 2 years supervised release as a result of his conviction for payment of Medicaid kickbacks. He was also ordered to pay \$22,000 in restitution to the New York State Medicaid program for his illegal kickback activity. From November 1996 through September 1997, he paid the woman, in her position as HHA executive director, \$2,000 a month in return for being hired to perform the annual medical screening required for each of the 1,500 home attendants employed by the company. Finally, the woman's daughter and two others were sentenced for their involvement in the Medicaid fraud schemes to probation and restitution totaling \$144,580.
- In Tennessee, two individuals were sentenced for fraudulently obtaining Medicare funds in excess of \$630,000. These individuals joined others in a scheme to submit false management fees on the cost reports of HHAs in which they had a controlling or ownership interest. One of the individuals was sentenced to 46 months imprisonment, 3 years supervised release and ordered to pay \$150,000 in restitution. The other was sentenced to 16

months imprisonment, 3 years supervised release and ordered to pay \$145,764 in restitution.

- A registered nurse and former owner of a Texas HHA was sentenced to 5 years probation, 6 months home confinement and payment of \$241,472 in restitution for defrauding Medicare. The woman fraudulently inflated the HHA's 1995 Medicare cost report by including a variety of inappropriate expenses. These expenses included costs for other businesses she owned, accrued bonuses that were not paid, nonallowable interest expenses and nonallowable marketing costs.
- Four Maryland HHAs agreed to pay the Government a total of \$253,639 to resolve their False Claims Act liability for submitting Medicare claims for services performed by an unlicensed, untrained physical therapist whose credentials the HHAs failed to check. The woman's scheme involved posing as a physical therapist and moving from one HHA to another, purportedly providing physical therapy services to Medicare beneficiaries. To carry out her scheme, the woman used a fictitious Social Security number and Maryland physical therapy license. She also provided fictitious references and educational information. Three of the HHAs entered into 3-year corporate integrity agreements with OIG, aimed at their credentialing and license verification practices. The fourth HHA agreed to similar types of 3-year compliance provisions as part of its settlement agreement. In addition, the woman and her husband, a co-conspirator in the scheme, were sentenced to 10 months (with 4 months suspended) and 24 months imprisonment, respectively, on charges of health care fraud and income tax evasion related to this scheme to defraud HHAs, Medicare and private insurers. The wife was also ordered to pay restitution of \$5,000. By portraying themselves as licensed physical therapists, the couple caused various HHAs to file false Medicare and private health insurance claims for physical therapy services not provided.

Fraud Involving Nursing Homes

Nursing facilities and their residents have become common targets for fraudulent schemes by which health care providers, medical professionals, nursing facility staff and others associated with the operation of nursing homes, improperly bill Medicare and Medicaid. Through such arrangements, Federal health care programs are billed for medically unnecessary services and for services either not rendered, or not rendered as described. Examples of fraudulent schemes involving nursing facilities and their residents are as follows:

- As noted in the Highlights section (see page ii), a national nursing home chain agreed to a global settlement for the submission of false cost reports to Medicare. Under the settlement, a subsidiary corporation that owns 10 nursing homes pled guilty to wire fraud and false statements associated with its Medicare cost reports and agreed to a \$5 million fine. In addition, the parent company agreed to pay a total of \$170 million over 8 years. From 1992 through 1998, the chain operated hundreds of distinct part nursing facilities. In order to justify greater reimbursement to the Medicare parts of these facilities, the company reported that its nurses were spending a disproportionate share of their time on Medicare patients. In fact, the allocation of nursing time was based on time records that were fabricated after the fact or otherwise wholly unreliable. As a result of the conviction of the subsidiary, the company must divest itself of the 10 nursing homes owned by the subsidiary. In addition to the criminal and civil resolution, the company agreed to a corporate integrity agreement that will remain in effect for 8 years.
- The United States Attorney's Office for the Eastern District of Pennsylvania announced the settlement of a False Claims Act lawsuit against a Pennsylvania nursing home management company and four of its officers, for submitting improper Medicare and Medicaid cost reports. According to the agreement, the company and its officers will pay the Federal Government and the Pennsylvania Department of Public Welfare a total of \$2.1 million to settle claims resulting from a qui tam lawsuit filed and subsequent investigation into unallowable administrative expenses claimed for reimbursement by Medicare and Medicaid. The company manages a chain of 19 nursing homes throughout Pennsylvania. During the period 1993 through 1996, the management company falsely inflated the administrative expenses claimed for reimbursement on their home office cost reports. Improper expenses included salaries and benefits for "ghost" employees, personal automobile expenditures and other unrelated business ventures, such as a gold mining company operating in Armenia and Russia. In addition to the \$2.1 million payment and a corporate integrity agreement, two of the officers agreed to 5-year exclusions and one to permanent exclusion.
- A man in Indiana was sentenced for mail fraud to 12 months and 1 day imprisonment, 3 years supervised release and payment of \$37,584 in restitution. In November 1998, he stole a Medicaid check in the amount of \$88,087 and attempted to steal Medicare checks from a nursing home he once owned. The man improperly submitted letters to the nursing home's contractors requesting the contractors to change the remittance address on

program checks from the nursing home to a post office box under his control. He was also involved in a fraudulent scheme which involved theft of Social Security checks and resident funds. These funds should have been forwarded to residents' new facilities after the Indiana State Department of Health ordered his facility closed due to serious health and safety violations.

Year 2000 Readiness

Performance Measure

At the request of the Congress and of HCFA, OIG released follow-up reports assessing the Year 2000 (Y2K) readiness of Medicare MCOs and Medicare fee-for-service providers.

A. Managed Care Organizations

The OIG received follow-up surveys from 161 MCOs in July and August 1999. Also, OIG reviewed data from HCFA's 59 site visits representing 204 managed care plans. Over four-fifths of MCOs respondents claimed that they were Y2K ready and about half indicated that they were taking steps toward ensuring compliance with external partners. Further, about 80 percent reported developing contingency plans and about 30 percent reported testing their plans. (OEI-05-98-00591)

B. Fee-for-Service Providers

The OIG sent anonymous follow-up surveys to 5,000 providers representing five groups: acute-care hospitals, nursing facilities, home health agencies, DME suppliers and physicians. In the 6 months between OIG's two surveys, health care providers generally reported improvements in the status of their billing systems, medical records systems and biomedical equipment. Providers were also more likely to report having completed contingency plans than they were 6 months earlier. However, some providers were further along than others and some still reported not taking the necessary steps to ensure Y2K readiness. In addition, a large number of providers did not respond to OIG's survey.

The OIG suggested that HCFA and the provider associations continue their outreach and education initiatives, focusing on the need to test data exchanges as well as internal computer systems, stressing the importance of contingency planning and publicizing websites where Y2K information was available. The HCFA agreed with OIG's conclusions and outlined their future plans in this area. (OEI-03-98-00253)

Contractor Costs for Year 2000 Remediation of Medicare Computer Systems

The HCFA, its carriers and FIs use several hundred computer systems to carry out their daily Medicare activities. Of these systems, 100 are designated "mission critical" because they are necessary both to establish the Medicare eligibility of beneficiaries and to authorize payments to fee-for-service providers and managed care plans. The Medicare contractors operate 75 of these "mission-critical" computer systems. During FY 1998, HCFA increased

the budget allocation of the contractors by over \$100 million for the Y2K remediation of their Medicare computer systems and related Y2K activities. To monitor the budget process associated with this additional funding, HCFA implemented a new structure for use by contractors in submitting their supplemental budget requests for Y2K funding and reporting Y2K expenditures on their interim expenditure reports.

At HCFA's request, OIG conducted a series of audits of costs reported by Medicare contractors for Y2K remediation of their Medicare computer systems and related activities. The audits sought to reconcile Medicare Y2K expenditures reported on selected interim reports to the contractors' accounting records and determine whether expenditures were: allowable in accordance with Medicare cost principles; expended for the remediation of Medicare computer systems or related Y2K activities; and properly allocated when used for remediation of systems and other Y2K activities that benefitted both Medicare and non-Medicare purposes. Separate reports were issued on each contractor audited. (CIN: A-01-99-00515; CIN: A-02-99-01015; CIN: A-02-99-01027; CIN: A-03-99-00018; CIN: A-03-99-00036; CIN: A-04-99-02153; CIN: A-04-99-02154; CIN: A-04-99-02155; CIN: A-04-99-02156; CIN: A-04-99-02157; CIN: A-04-99-02158; CIN: A-05-99-00032; CIN: A-05-99-00037; CIN: A-05-99-00058; CIN: A-05-99-00059; CIN: A-06-99-00034; CIN: A-06-99-00046; CIN: A-06-99-00052; CIN: A-07-99-02055; CIN: A-07-99-02059; CIN: A-07-99-02065; CIN: A-07-00-02067; CIN: A-07-99-02063; CIN: A-09-99-00077; CIN: A-09-99-00078; CIN: A-09-99-00088; CIN: A-10-99-00003; CIN: A-10-99-00004; CIN: A-14-99-00401; CIN: A-17-99-01999)

Medicare Administrative Appeals: Hearing Process

The OIG examined the administrative law judge (ALJ) appeals process for Medicare Part A fee-for-service claims and Medicare Part B claims. A hearing with an ALJ is the second step in appealing a denied Part A claim and the third step in appealing a denied Part B claim. If an ALJ upholds a denied Part A or Part B claim, an appellant may request a review by the Departmental Appeals Board (DAB), the final level of administrative appeal.

The OIG found that an increasing number of appeals are being heard by ALJs and noted some serious deficiencies in the ALJ appeals. To correct structural problems, OIG recommended that HCFA separate the administrative appeals process for beneficiaries and providers; establish adversarial ALJ hearings for provider appeals; develop and require both Medicare contractors and ALJs to apply the same standards; develop regulations for conducting Medicare ALJ appeals; establish a case precedent system for DAB rulings; develop thorough, parallel training programs for Medicare contractors and ALJs; and create formal communication and information networks that span the entire appeals environment. Further, OIG proposed that a dedicated ALJ corps be established, and submitted three organizational options for such a corps. The HCFA concurred with OIG's findings and recommendations. (OEI-04-97-00160)

Safeguarding Medicare Accounts Receivable

Performance Measure

The OIG reviewed the Medicare accounts receivable balance as of October 1, 1998 and activity from that date through March 31, 1999 at HCFA central and regional offices. Medicare accounts receivable are amounts owed to the Federal Government, primarily due to previous overpayments.

The OIG found that regional and central office accounts receivable were misstated by \$184.5 million and that another \$376 million should be written off because the receivables were several years old and there was no evidence of any recent collection effort. These problems arose because HCFA does not have a functioning, integrated financial management system in accordance with Office of Management and Budget Circular A-127. In addition, overall responsibility for collecting and managing accounts receivable is dispersed among the Medicare contractors, the 10 HCFA regional offices and the central office; this diffusion of responsibility has contributed to many of the problems noted and has precluded timely referral of debt for cross-servicing and the Treasury offset program.

Unless HCFA makes appropriate adjustments for erroneous receivables and corrects the internal control deficiencies identified, its future financial statements will be misstated. The OIG made specific recommendations to HCFA to develop controls to ensure that central and regional office accounts receivable balances are complete, supported and accurately reported. The HCFA generally concurred with OIG's findings and recommendations. (CIN: A-17-99-11999)

Medicare Administrative Costs

The HCFA contracts with private insurance companies (FIs and carriers) to process and pay Medicare claims. The OIG reviewed the allowability of costs claimed for Parts A and B reimbursement by two contractors.

A. AdminaStar Federal

This audit covered costs claimed by AdminaStar Federal on its final administrative cost proposals for FYs 1996 and 1997. Of the total \$169.7 million claimed, OIG recommended a financial adjustment of \$3.1 million. The unallowable costs included, among other things, almost \$1.7 million in overstated pension costs, about \$447,000 in overstated return-on-investment costs and \$398,000 in excessive executive salary increases. The contractor concurred in more than \$2.4 million of the questioned costs but disagreed with the remainder. (CIN: A-05-98-00042)

B. Blue Cross Blue Shield of Texas

Under contract with OIG, a certified public accounting firm audited the costs claimed on Blue Cross Blue Shield of Texas's (BCBST's) final administrative cost proposals for Medicare Parts A and B for the period October 1, 1994 through September 30, 1998. While

the firm concluded that BCBST had generally established adequate systems of internal control, accounting and reporting for administrative costs and that most of the costs claimed for the period were allowable, it did identify \$1.6 million in unallowable charges. The OIG recommended a financial adjustment in that amount. (CIN: A-06-99-00006)

Pension Plan Audit

Blue Cross and Blue Shield of Massachusetts (BCBSM) was a Medicare Parts A and B contractor until its contract was terminated in 1997 and, as such, was reimbursed for its Medicare employees' pension costs until that time. Regulations and the Medicare contracts provide, however, that pension gains attributable to the Medicare segment of a terminated contractor's pension plan be credited to the Medicare program. The OIG identified approximately \$5.3 million in excess pension assets at BCBSM which should be remitted to the Medicare program. (CIN: A-07-99-02537)

Medical Billing Software and Processes Used to Prepare Claims

Billing Medicare, and the 2,800 plus other health insurers, has become a complex endeavor, according to this OIG inspection. Most providers, or their billing agents, use medical billing software to prepare claims. Software can be misused to maximize reimbursement and to submit false claims. It does little to reduce human error inherent in the claims preparation processes. (OEI-05-99-00100)

Criminal Fraud

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false claims or statements. Such false claims may be pursued civilly under the False Claims Act (see, for example, the hospital initiatives described in pages 10-13). In appropriate cases, false claims may also be prosecuted criminally as Federal offenses such as mail fraud, wire fraud, false statements and various health care fraud offenses. Following are descriptions of criminal prosecutions which resulted from the investigation of both false claims-related offenses and other health care-related offenses during this period:

- Four corporate officers were sentenced for engaging in improper activities while administering Medicare contracts in New York. The former chief operating officer (COO) of the Medicare carrier for upstate New York was sentenced to 2 years imprisonment and a \$15,300 fine; he was found guilty of committing fraud related to the carrier's Medicare contract with HCFA and of causing false information to be submitted to HCFA on the carrier's 1992 Contractor Performance Evaluation Program (CPEP). The former COO of a northeastern New York subsidiary of the carrier was sentenced to 8 months home confinement and 3 years probation for aiding and abetting the carrier's COO in 1992, by generating false documentation to show that

private side employees with the subsidiary performed Medicare-related work. Further, the carrier's former vice-president was sentenced to 1 year probation; he previously pled guilty to making false statements to HCFA on the carrier's 1992 CPEP by falsely indicating that the carrier processed reviews and hearings within acceptable time frames. Another former vice-president of the carrier was sentenced to 1 year probation; she previously pled guilty to causing a false statement to be submitted to HCFA on the carrier's 1992 final administrative cost proposal.

- In Florida, two individuals were sentenced for conspiracy to defraud the Medicare program to 2 years imprisonment, 3 years supervised release and payment of \$500,000 in restitution. The two engaged in a scheme which utilized patient recruiters to find beneficiaries eligible for Medicare. These beneficiaries were brought to a clinic one of the individuals owned and operated, where they were fraudulently diagnosed with chronic pulmonary disease. They were then provided with oxygen nebulizers and inhalation solutions provided by a DME company owned and operated by the second individual. Medicare was billed, in turn, for these medically unnecessary services and equipment, resulting in an estimated loss to the Medicare program of \$1.2 million.
- A Texas woman was sentenced for theft of Federal funds and false statements to 21 months imprisonment, 3 years supervised probation and payment of \$1.1 million in restitution. She and another individual, previously sentenced for her role in the scheme, owned and operated a billing company through which they submitted fraudulent Medicare and Medicaid claims using their clients' provider numbers. Through this scheme, the two improperly received checks mailed to the company and embezzled the funds.
- A chiropractor and a second individual were sentenced for mail fraud in Illinois. The chiropractor was sentenced to 1 year and 1 day incarceration, 3 years probation and \$106,132 in restitution. The second individual was sentenced to 6 months incarceration, 3 years probation and \$106,132 in restitution. Previously, a medical doctor, also involved in the scheme, was sentenced for mail fraud to 4 months incarceration in a community confinement center, 5 years probation and \$106,132 in restitution. The three submitted false claims to Medicare on behalf of a noninvasive cardiovascular diagnostic testing laboratory. Claims were submitted for tests which had not been ordered by a physician and for office visits which never occurred. The chiropractor and the second individual owned and operated the laboratory. The chiropractor interpreted the test results, and the

second individual, a former associate county judge, was the office administrator. The medical doctor acted as the staff physician. The laboratory obtained most of their patients through free health care "screenings" at senior citizen centers or through referrals from chiropractors. After reviewing the noninvasive cardiovascular test data, the chiropractor would prepare a report with his interpretation of the data. During the investigation, the Medicare contractor reviewed a sampling of the laboratory's patient files and criticized the chiropractor's interpretation of the test data and his consistent recommendation of nutritional supplements marketed by him and his wife. The Medicare contractor also cited a number of instances in which the chiropractor overlooked major illnesses such as leukemia, diabetes, anemia and syphilis.

- In Maryland, an individual was sentenced to 12 months and 1 day incarceration, 36 months supervised release and payment of \$145,589 in restitution. The individual pled guilty to bank fraud for his role in a scheme to assume the identities of unsuspecting HHS employees, as well as other non-HHS individuals, for the purpose of committing bank fraud. A joint investigation with the U.S. Postal Inspection Service and the Social Security Administration identified this individual as part of a larger conspiracy to commit bank and credit card fraud. The group of conspirators secured HHS personnel information from documents placed in a shred bin for disposal at an HHS Program Support Center (PSC) facility. The fraud ring then used the stolen HHS employee data to obtain identification cards, open bank accounts and secure credit cards. Their elaborate scheme not only compromised HHS employee data, but also resulted in an aggregate loss of over \$456,883. As a result of this incident and in order to prevent future thefts, OIG advised the PSC to implement administrative controls to safeguard the accessing, printing and disposal of confidential personnel information. The PSC agreed to take the necessary measures to improve these controls.
- As the result of a joint investigation with the Food and Drug Administration, the Drug Enforcement Administration and the Pennsylvania Medicaid Fraud Control Unit, a pharmacist was sentenced based on an earlier guilty plea to knowingly and intentionally distributing controlled substances and to sale or receipt of stolen goods. While employed as a pharmacist, the individual stole controlled substances from the pharmacy where he worked and then sold these substances to street dealers. His sentence included 6 months community confinement, 3 years probation and payment of \$13,410 in restitution.

- A Missouri chiropractor was sentenced to 5 years probation, 4 months home confinement and payment of \$15,456 in restitution for false statements on an application for payment under the Medicare program. The chiropractor submitted numerous Medicare claims for back manipulation procedures without the X-ray required. The defendant misrepresented on the forms that patients had an X-ray when he knew they had not.
- A New York man was sentenced to 3 years probation and a \$275 fine for possession of a false United States Government document. He attempted to use a fraudulent Medicare card to unlawfully obtain city transit discounts granted to those with Medicare entitlement. The man, who has an extensive criminal history including robberies and drug sales, will also be required to attend weekly drug counseling.

Kickbacks

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are made in exchange for anything of value, however, both the giver and receiver may violate the Medicare and Medicaid anti-kickback statute.

Among its provisions, the anti-kickback statute penalizes anyone who knowingly and willfully solicits, receives, offers or pays remuneration in cash or in kind to induce or in return for:

- referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or
- purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs.

Violators are subject to criminal penalties and to exclusion from participation in Federal health care programs. They may also be subject to civil monetary penalties (CMPs). The following cases are examples of the sentences for this crime:

- A licensed physician was sentenced in Connecticut to 4 months imprisonment, 4 months home confinement, 4 years supervised probation and payment of \$10,200 in fines. He also forfeited \$60,000 to the

Government. From May 1995 through December 1997, the physician solicited and received kickbacks in exchange for patient referrals for DME. Through this illegal kickback scheme, he received approximately \$78,130 in payments which he failed to report as income on his 1995 tax return.

- In Nebraska, a mental health center agreed to pay the Government \$106,574 to resolve allegations of paying kickbacks to a psychiatric clinic in order to induce Medicaid, psychiatric, inpatient referrals to the center. The Government alleged that between 1987 and 1993, the center paid over \$2,000 a month as a charitable contribution to a nonprofit entity, which was in turn paid over to an outpatient mental health facility. These payments were allegedly made to induce the referral of Medicaid patients from this facility to the center. The center is no longer enrolled as a Nebraska Medicaid provider, and the individuals involved are no longer associated with the center.
- In Florida, an individual was sentenced to 2 years probation, a \$2,000 fine and payment of \$863 in back taxes to the Internal Revenue Service for failure to file an individual income tax return for 1994. He is the fifteenth individual sentenced in connection with an investigation involving numerous impotence clinics in Florida which allegedly billed Medicare and CHAMPUS (now TRICARE) for medically unnecessary services. The investigation determined that numerous individuals, owning numerous diagnostic companies, paid illegal kickbacks to the owners of these impotence clinics during 1994 and 1995. At that time, the individual sentenced worked as a salesman for a diagnostic company owner. As part of his duties, the individual paid kickbacks to impotence clinic owners in exchange for Medicare patient referrals.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,476 administrative sanctions, in the form of program exclusions or civil actions, on individuals and entities for engaging in fraud or abuse or other activities deemed to be a risk to Federal health care programs and/or their beneficiaries.

A. Program Exclusions

Title XI of the Social Security Act provides for a number of bases for excluding individuals and entities from participation in Medicare, Medicaid and other Federal health care programs. Exclusion is mandatory for those convicted of program-related crimes, crimes related to patient abuse or neglect, felony convictions for defrauding other health care programs, and felony convictions for the illegal manufacture or distribution of controlled substances. Exclusion is discretionary for those who have lost a license to practice or the

right to participate in a State health care program for reasons related to professional performance, professional competence or financial integrity, or provided substandard or unnecessary services. Exclusions may also be imposed on those convicted of private insurance fraud, or obstruction of an investigation, and on individuals who have failed to repay health education assistance loans (HEALs). (See page 51 for further information on exclusions for HEAL defaults.)

During this reporting period, OIG imposed exclusions on 1,278 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A physician in California was excluded from participating in Medicare, Medicaid and all Federal health care programs for a period of 10 years, following his conviction in district court for sexual battery, child molestation and possession of child pornography. Abusing his position as the family physician, he induced the father of one of his 11-year old patients to allow him to take partially-nude photographs of the man's daughter. The physician was also ordered to serve 300 days in prison.
- In Colorado, the owner/operator of a medical staffing agency was excluded from program participation for 3 years. The individual fraudulently created and altered background check reports to show clear criminal records for employees contracted out by his agency. He was also forging Colorado nursing and certified nursing assistant licenses. He pled guilty to one count of second degree forgery, was sentenced to 2 years probation, and ordered to pay restitution in the amount of \$25,000.
- A diagnostic services clinic in Florida was excluded for 20 years due to its ownership by an individual convicted of money laundering. The entity was involved in a scheme to create 11 clinics and bill for nonrendered services for current and former Medicaid recipients, both living and deceased. The fraudulent claims falsely identified names and provider numbers of physicians who were not affiliated with the clinics. This resulted in a combined loss to the Medicaid program in excess of \$900,000. The convicted individual was sentenced to 45 months incarceration and ordered to pay restitution and fines of close to \$800,000, and excluded by OIG for 20 years.
- In Texas, a physician was excluded indefinitely because her license to practice medicine or provide health care in that State was suspended for reasons bearing on her professional competence. The physician prescribed drugs to her family and failed to keep any medical records regarding those treatments.

- The president of a company providing mobile x-ray services to Medicare beneficiaries in Kansas was excluded for 15 years after being found guilty of conspiracy to defraud the Government, submitting false claims, aiding and abetting and mail fraud. The individual submitted false claims to Medicare by claiming full transportation fees for each individual patient seen by x-ray technicians of the company, when multiple patients were actually seen during the nursing home trip for which the claim was made. After being convicted, the individual was sentenced to 48 months imprisonment and ordered to pay restitution totaling almost \$600,000.
- In Oklahoma, an employee at a mental health facility was excluded for 10 years for patient abuse. While employed at the facility, the individual pushed a beneficiary's head into a wall and then kicked the beneficiary in the legs and body. The individual was sentenced to 5 years incarceration, all of which was suspended except for 30 days with credit for time served, and placed on 2 years probation.
- A registered nurse in Missouri was excluded for 10 years after being convicted of a criminal offense related to the delivery of an item or service under the Medicaid program. She was also convicted of a felony related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. She used a Medicaid beneficiary's name to obtain medication by fraud, which caused the pharmacy to bill the Medicaid program for prescriptions provided to a beneficiary when, in fact, she diverted the medication for her own use. She was sentenced to serve 5 years in prison.
- A physician in Louisiana was excluded from program participation for a minimum of 10 years after pleading guilty to two charges of mail fraud. The physician submitted claims to Medicare and Medicaid for psychiatric services that were not provided. The court placed the physician on supervised probation for 4 years and home confinement for 1 year. The individual was also ordered to pay fines and restitution totaling \$500,200.

B. Civil Penalties for Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. 1395dd) provides that when an individual presents to the emergency room for examination or treatment, a hospital which has a Medicare provider agreement is required to provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, treatment to stabilize the condition, unless a physician certifies that the individual should be transferred because the benefits of medical

treatment elsewhere outweigh the risks associated with transfer, or if the patient requests to be transferred after being advised of the inherent risks. If a transfer is ordered, the transferring hospital must arrange for a safe transfer, which includes providing stabilizing treatment to minimize the risks of transfer, making sure the receiving hospital has agreed to accept the transfer and effecting the transfer through qualified personnel and transportation equipment. A hospital is prohibited from delaying provision of examination or treatment for an emergency medical condition to inquire about an individual's method of payment or insurance status. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs those services if the hospital has the capacity to treat the individual.

The OIG is authorized to impose CMPs of up to \$25,000 against small hospitals (less than 100 beds) and up to \$50,000 against larger hospitals (100 beds or more) for each instance where the hospital negligently violated any of the section 1867 requirements. In addition, OIG may impose a CMP of up to \$50,000 against a participating physician, including an on-call physician, for each negligent violation of any of the section 1867 requirements.

Between October 1, 1999 and March 31, 2000, OIG collected \$643,500 in settlement amounts from 24 hospitals and physicians. The following is a sampling of the alleged violations involved in the FY 2000 Patient Anti-Dumping Statute settlements from this reporting period.

- A small Indiana psychiatric hospital paid \$30,000 to settle allegations that it failed to provide appropriate medical screenings and transfers for two patients. One of the patients had a clear emergency medical condition, but was not screened or treated because he was not able to come up with a \$2,000 down payment for medical services.
- In Maryland, a small hospital settled allegations that it failed to provide appropriate medical screening examinations in a number of cases where only the patients' vital signs were taken before they were discharged. The patients' primary care providers had been called for payment authorization, and such authorization was denied. One patient had been kicked in the face and presented with jaw pain, missing teeth and bleeding; another patient was having difficulty breathing and sleeping, and had been vomiting. The hospital settled for \$60,000.
- After a hearing, an administrative law judge imposed a \$25,000 CMP on an Oklahoma hospital which refused to accept the appropriate transfer of a patient who had been critically injured in an automobile accident and required emergency vascular surgery. The transferring hospital did not have the specialized capabilities or facilities that were required to treat the life

threatening injury to the patient's abdominal aorta. After numerous calls to hospital emergency rooms and physicians, the patient was transferred to a hospital where surgery was performed in an attempt to save his life. The patient, however, died from his injuries and their aftereffects. The Oklahoma hospital has filed an appeal with the Departmental Appeals Board.

- In order to resolve allegations that it failed to provide appropriate medical screenings for several individuals, a California hospital paid \$67,000 in penalties. In one case, a patient was asked to pay for services prior to being treated. In others, managed care companies denied payment authorization and/or patients were instructed to see their doctors or go to a clinic instead of being seen at the hospital. Patients presented to the hospital with conditions including multiple dog bites and pneumonia.
- A small Arkansas hospital settled an allegation that it failed to provide a 1-year old patient a medical screening examination by paying \$15,000. The infant presented with a high fever and earache, and exhibited extreme discomfort when held. Two days later she was diagnosed at another hospital with bacterial meningitis. She is permanently deaf.
- A California emergency physician agreed to pay \$6,000 as he allegedly inappropriately transferred a patient with a suspected intracranial bleed. Although the physician provided the patient with a screening examination after being informed the patient's MCO had denied treatment, the patient was nonetheless inappropriately transferred in an unstable condition.
- A hospital in Florida settled, for \$35,000, an allegation that it failed to medically screen a patient with new onset of diabetes mellitus. The hospital allegedly refused treatment when the patient indicated he could not make a requested deposit and, instead, referred him to a clinic or the health department for treatment the next day. Upon leaving that hospital, however, the patient immediately presented to another hospital where he was admitted and discharged 3 days later.
- An Oregon hospital paid \$125,000 to settle allegations that it failed to provide several patients with appropriate medical screening examinations. The patients' MCOs denied payment authorization for treatment. In one instance, a patient presented to the emergency room complaining that he could not move the right side of his face. Another instance concerned a 5-year old who presented with a stomachache of several days duration. The next day a pediatrician saw this child and immediately sent him to surgery

for a ruptured appendix. Also, in another instance, a pregnant patient who had sharp abdominal pain went by car to another facility, without being medically screened, apparently because of insurance concerns.

C. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers and others who submit false or improper claims to Medicare and other Federal health care programs. The OIG also assists DOJ in bringing (and settling) cases against wrongdoers under the False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity agreements on entities as a condition for being allowed to remain a provider in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue. The Government, with the assistance of OIG, recouped more than \$800 million through both CMP and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period. Some examples of these cases include:

- As noted in the Highlights section (see page ii), the United States entered into a global settlement with the Nation's largest provider of kidney dialysis services and several of its subsidiaries, in which the provider agreed to pay approximately \$486 million to settle allegations from a multi qui tam investigation. As part of the civil settlement agreement for credit balances, the company paid directly to HCFA \$11 million for overpayments which were previously reported to the FIs but never recouped. The allegations included the following: billing of unnecessary end stage renal disease (ESRD) laboratory tests and the paying of kickbacks to induce the ordering of such unnecessary tests; billing for noncovered intradialytic parenteral nutrition (IDPN) services, falsifying documents to obtain payment, and the paying of kickbacks in the form of "hang fees" and other forms of remuneration to induce the ordering of unnecessary IDPN services; failing to report "credit balances" and/or "unreconciled payments" and/or converting such monies to income rather than returning the monies to the Federal health care programs; and billing for certain unnecessary diagnostic tests performed under clinical studies. As part of the settlement agreement, the provider agreed to adhere to an 8-year corporate integrity agreement. In addition, three of its subsidiaries pled guilty to criminal offenses, and agreed to permanent exclusion from the Federal health care programs. This settlement represents the largest Medicare fraud settlement ever reached and is the result of a joint effort by OIG investigators and auditors along with other law enforcement agencies. There was also an agreement to resolve a large volume of IDPN claims through the end of 1999. In exchange for the provider surrendering its right to seek payment and pursue appeals for these

claims (which the provider asserted were worth about \$196 million), HCFA agreed to pay or "credit" the provider about \$59 million.

- As noted in the Highlights section (see page ii), a former Medicare FI agreed to pay nearly \$74.3 million to resolve its civil liability under the False Claims Act and Civil Monetary Penalties Law. The OIG investigation determined that, between 1989 and 1991, the intermediary falsified interim payments on settled hospital cost reports in order to meet HCFA's contractor performance evaluation standards. As a result of this activity, the intermediary improperly paid to, or made cost report adjustments for, several hospitals. The affected hospitals either received cash payments to which they were not entitled or had their cost reports adjusted so that they paid less back to Medicare than they should have paid. As part of the settlement, the company, which is no longer an intermediary, agreed to the imposition of a corporate integrity agreement for 5 years for its Medicare+Choice HMO contract, which it still operates.
- A New York school of medicine agreed to pay the Government approximately \$2.3 million to resolve allegations of improperly billing Medicare. The school obtained excess Medicare funds based on claims for professional services rendered to Medicare beneficiaries that were not documented or not in compliance with Medicare's coding and reimbursement rules. As part of the settlement, the school entered into a 5-year, institutional compliance agreement requiring the facility to maintain a compliance committee and to perform an annual review of its billing for professional services.
- In Mississippi, the Government entered into a settlement agreement with a clinical laboratory, a physician and another individual to resolve allegations that the laboratory submitted false claims to Medicare. As part of the settlement, the laboratory agreed to pay \$1.2 million to resolve its civil and administrative liabilities for the improper conduct and to enter into a comprehensive, 5-year corporate integrity agreement with OIG. The clinical laboratory allegedly submitted false claims by billing for tests to identify a certain bacteria after a preliminary test showed no bacteria present and by unbundling certain urinalysis tests. The physician involved in the settlement owns the laboratory, and the other individual was the laboratory manager during the time period at issue.
- In Virginia, a health care corporation and a hospital agreed to pay the Government a total of \$726,063 to settle allegations of improprieties occurring in the hospital's psychiatric programs. The hospital contracted

this corporation as a health care consultant to manage the hospital's psychiatric unit. Investigation showed that from July 1994 through April 1997, the corporation inappropriately admitted patients to the hospital; that patients at the facility stayed longer than medically necessary; and that the corporation and the hospital failed to provide adequate treatment plans for patients enrolled in the facility's partial hospitalization program.

- A consent judgment was entered against a physician and the largest, independent physiological laboratory in Colorado, holding them jointly and severally liable for payment of \$170,500 to the Government. This settlement resolved the civil aspect of the case and occurred in conjunction with a guilty plea to a criminal false claims violation. Based on this guilty plea, the physician was sentenced to 4 months imprisonment and 3 years probation. Through his laboratory, the physician improperly billed for pulse oximetry tests not performed, stress tests when pulse oximetry tests were performed, and home evaluation and management visits not performed. As part of the global settlement, the physician agreed to a 7-year exclusion as well. Also in connection with this case, a second individual pled guilty to theft of public monies for billing Medicare for pulse oximetry tests not performed. This individual, who previously sold the laboratory to the physician, was sentenced to 2 years probation.
- In Alabama, a kidney clinic and physician agreed to pay the Government \$90,000 to resolve allegations of improper billing for dialysis treatments. During the period from 1987 through 1992, the clinic and physician allegedly billed Medicare for patients who were no shows and for patients who appeared but could not receive their scheduled treatment due to medical complications. The clinic also entered into a comprehensive, 3-year corporate integrity agreement with OIG.

Under the Civil Monetary Penalties Law (CMPL), 42 U.S.C. 1320a-7a, OIG has authority to proceed administratively against persons or entities who submit false, fraudulent or improper claims for payment under Medicare and other Federal health care programs, e.g., Medicaid. Under the CMPL, OIG may impose a CMP of not more than \$10,000 for each item or service falsely claimed, and an assessment of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. Persons or entities may also be excluded from participation in Federal health care programs under this authority.

- The successor entity of a California physician partnership, which primarily provided medical services to nursing home patients, agreed to pay \$1.4

million for allegedly submitting false claims to Medicare. The successor entity also agreed to comply with a 5-year corporate integrity agreement.

- A Florida podiatrist, who received kickbacks from a DME supplier in exchange for ordering lymphedema pumps for program beneficiaries, agreed to a 3-year exclusion and paid \$30,000 in penalties to resolve the allegations. The podiatrist prescribed pumps which were expensive and not medically necessary for treatment of the beneficiaries' conditions.
- A Pennsylvania physician, who had been excluded for 10 years, settled his liability under the CMPL, by paying \$30,000. The physician had submitted claims to the Medicare program while excluded from program participation.

D. Compliance Activities

The existence of an "effective" compliance program can offer an organization certain credit under the Federal Sentencing Guidelines. This and other benefits have served to encourage the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct and to detect violations under the False Claims Act and the CMP law. The OIG has already initiated significant outreach efforts with the private sector to discuss these compliance endeavors.

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various sectors of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals, HHAs, third-party billing companies, DME, prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans and nursing homes. The OIG is currently working on guidance for other sectors of the industry, including individual physician and small physician group practices, and ambulance service providers. As noted in the Federal Sentencing Guidelines, the seven fundamental elements of an effective compliance program are: implementing written policies, procedures and standards of conduct; designating a compliance officer and compliance committee; conducting effective training and education; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives.

Copies of OIG's compliance program guidances, as well as other materials developed by OIG as part of its effort to identify and curb health care waste, fraud and abuse are available on the Internet at <http://www.hhs.gov/oig>.

In addition to developing compliance program guidance, OIG monitors compliance and integrity obligations imposed on health care providers as part of global settlements of OIG

investigations and audits. These obligations are typically imposed through an agreement commonly referred to as a corporate integrity agreement. Presently, OIG is monitoring 440 Government-imposed corporate integrity agreements. These agreements cover the range of providers from small physician offices to large hospitals and laboratory corporations. The duration of most current corporate integrity agreements is 5 years and these agreements require a substantial effort by the provider to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. A material failure to adhere to the corporate integrity agreement could result in financial penalties or exclusion of the provider in addition to other penalties.

As one of its six task orders awarded to program safeguard contractors, in November 1999, HCFA contracted with TriCenturion, LLC, a new company formed by three current Medicare contractors (Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of South Carolina and TrailBlazer Health Enterprises) to assist OIG in its monitoring of providers subject to corporate integrity agreements. In the next contract year, TriCenturion will perform 27 onsite reviews of providers subject to corporate integrity agreements to assist OIG to determine if the providers are meeting the obligations in the agreements. In addition, TriCenturion will conduct claims reviews to determine whether the providers are complying with applicable laws. The OIG staff will work closely with HCFA and TriCenturion on this important project. This effort will complement the site visits conducted by OIG's compliance unit staff.

Beneficiary and Provider Outreach Activities

The national initiative against waste, fraud and abuse in the Medicare program was launched on February 24, 1999 by the Department (including OIG, HCFA and the Administration on Aging [AoA]), the American Association of Retired Persons (AARP) and DOJ (including the Federal Bureau of Investigation [FBI]). Since that date, OIG has maintained a collaborative partnership with each of these agencies to continue the efforts that began over a year ago. Monthly meetings are held to update partners on individual activities conducted by each respective partner and to plan for future collaborative activities. Since the event, the OIG hotline has served as an educational and reporting resource to approximately 552,000 callers. The hotline continues to experience an increase in calls from Puerto Rico and maintains a monitoring program to ensure that concerns of the Hispanic community are addressed.

The OIG continues to distribute hundreds of its Medicare fraud educational materials to beneficiaries through AoA grantees, the AoA network and Medicare carrier organizations, and to State libraries nationwide. Working relationships have been developed with Hispanic organizations to distribute Medicare fraud materials currently translated and printed in Spanish to Hispanic Americans; this Spanish-version material has been revised based on guidance and advice from these national Hispanic representatives. Working relationships have also been established with Asian American organizations to distribute Medicare fraud

materials that may ultimately be translated and printed in Mandarin Chinese for Chinese Americans.

In addition to beneficiary outreach, OIG has made progress in working with provider groups. Specifically, as a result of OIG's initial coordination, representatives from the American Hospital Association regularly attend the monthly outreach partner meetings. Several productive meetings have been held with the American College of Physicians/American Society of Internal Medicine, and the trifold brochure on Medicare fraud has been revised to incorporate comments from that organization. The OIG seeks to promote dialogue with other provider groups as well.

Accuracy of Unique Physician Identification Number Data

The unique physician identification number (UPIN) is a national number that distinguishes the individual ordering or furnishing the service or supply from the entity requesting or receiving Medicare reimbursement. In 1989, HCFA established the UPIN registry and assigned unique numbers to Medicare physicians. In 1994, the registry was expanded to include nonphysician practitioners and group practices. The registry also maintains data on each practice location, by provider identification number (PIN). The HCFA plans to use the registry information as source data for the national provider identifier, which will replace UPINs and PINs after the year 2000.

The OIG found that HCFA has taken meaningful actions to enhance the accuracy of UPIN data, but that problems continue to exist with some physician registry data. Almost one-fourth of the active UPINs have no recent Medicare claims activity; coding instructions and formats adversely affect the usefulness of information; some providers have numerous active PINs; and some UPIN data is inconsistent. To address these problems, OIG recommended that HCFA deactivate UPINs and PINs for inactive providers and practice locations; improve data entry for specific data fields, review individuals with numerous PINs; and reconcile identical fields in UPIN and PIN records before implementing the national provider identifier. The HCFA concurred with OIG's findings and has undertaken action to implement the recommendations. (OEI-07-98-00410)

Utilization Parameters for Chiropractic Treatments

The HCFA convened the Chiropractic Work Group to assist in developing new chiropractic policies required by the BBA of 1997. A utilization review parameter establishes a point at which a carrier will review each additional claim for medical necessity. The work group is considering two options, a utilization review parameter of 18 treatments per year and one of 12 treatments per year. The work group's director requested that OIG compile 1997 chiropractic utilization data and quantify the potential impacts of implementing the two options.

The OIG determined that implementing either option would ensure that Medicare pays for all chiropractic services that Medicare beneficiaries are entitled to and would help prevent payment for services not authorized under the program. By establishing utilization parameters at 18 or 12 beginning in 2000, OIG estimates that annual Medicare outlays would be reduced by about \$19.4 million or \$30.2 million, respectively. The OIG recommends a parameter of 12, the one most commonly used (by 29 of 55 carriers), which would require the least administrative change for carriers overall. If some carriers with lower existing parameters choose to increase their parameters up to the new maximum, OIG's savings estimate would be reduced. The HCFA will use this information in its effort to establish chiropractic utilization guidelines. (OEI-04-97-00496)

Outpatient Psychiatric Services

These audits were conducted in conjunction with OIG's review of Medicare's partial hospitalization programs at community mental health centers, which found significant error rates regarding provider compliance with Medicare requirements.

In its audit at one Connecticut hospital, OIG identified charges for psychiatric care that were not properly supported by medical records or were medically unnecessary. Based on a statistical sample, OIG estimated that at least \$1.9 million in outpatient charges did not meet Medicare reimbursement criteria. The OIG also identified \$212,372 in costs ineligible for Medicare reimbursement claimed on the hospital's FY 1997 cost report for outpatient psychiatric services.

Similarly, in an audit at a New Hampshire hospital, OIG estimated that at least \$314,359 in outpatient psychiatric charges did not meet Medicare reimbursement criteria. In addition, OIG identified \$11,315 in ineligible costs claimed on the hospital's FY 1998 cost report for outpatient psychiatric services.

The OIG recommended that the hospitals strengthen their procedures to ensure that charges for psychiatric services are covered and properly documented. Also, OIG recommended that the hospitals establish nonreimbursable cost centers or otherwise exclude costs related to noncovered services from their Medicare cost reports. The OIG will provide the results of the reviews to the FI so that it can apply the appropriate adjustments to the hospitals' cost reports. (CIN: A-01-99-00501; CIN: A-01-99-00502)

Durable Medical Equipment Regional Carriers: Meeting HCFA's Objectives

Performance Measure

In this inspection on durable medical equipment regional carrier (DMERC) efforts to meet HCFA's implementation objectives, OIG found that the DMERCs reduced claims processing costs by 15 percent; established medical policies for 87 of the top 100 utilized codes by the October 1993 deadline; developed education and fraud components; and eliminated carrier

shopping. Overall, they produced positive results and were able to prevent fraud, waste and abuse in such areas as incontinence supplies, wound care and lymphedema pumps. However, the DMERCs were not able to provide complete information to determine the quality of their fraud units' efforts, specifically information that indicated the source of the fraud case and whether overpayments were collected.

The OIG recommended that HCFA require the DMERCs to capture such information and incorporate these elements into its automated management system. The HCFA concurred with OIG's recommendation. (OEI-04-97-00330)

Medicare Payments for Orthotic Body Jackets

Between 1990 and 1992, Medicare allowances for orthotic body jackets coded L0430 rose sharply from \$217 thousand to \$18 million. In 1994, OIG reported that 95 percent of claims submitted in 1991 were for nonlegitimate orthotic body jackets and should not have been paid. The devices supplied were usually nothing more than a seat cushion for a wheelchair patient. In 1997, OIG reported that at least 19 percent of orthoses claimed for Medicare reimbursement were unnecessary.

In the current study, OIG found that, from 1994 to 1998, claims for orthotic body jackets under Medicare code L0430 had decreased over 50 percent and Medicare allowed charges decreased nearly 46 percent. In OIG's 1994 study, the devices allowed for Medicare payment under code L0430 were typically not orthotic body jackets, but rather seat cushions for wheelchairs. In the current inspection, the statistical analysis durable medical equipment regional carrier (SADMERC) expert determined that all 153 devices in the OIG sample claimed as body jackets qualified for Medicare reimbursement. The OIG did note that suppliers had upcoded 42 percent of 1996 L0430 orthotic body jacket claims; some of this may have been accounted for by the lack of uniformity and standardization in coding. The OIG also found that 3.5 percent of 1996 sample claims may have been for unnecessary duplicate body jackets.

The OIG recommended that HCFA review and revise the Medicare coding guidelines; require suppliers to include more information on their Medicare claims for the products they provide to beneficiaries; and encourage the DMERCs to continue or initiate system edits that detect multiple billings of orthotic body jackets to the same Medicare beneficiary in a calendar year. The HCFA disagreed with the first two recommendations. (OEI-04-97-00390)

Medicare Allowed Charges for Orthotic Body Jackets

In the States reviewed for this inspection, Medicare paid more for orthotic body jackets than Medicaid and TRICARE. Further, Medicare reimbursement rates allowed suppliers to mark up orthotic body jackets from 54 to 832 percent.

The OIG recommended that HCFA determine the appropriateness of Medicare allowed charges for orthotic body jackets. The HCFA should ensure that allowed charges provide reasonable profits for suppliers, and at the same time assure that charges do not result in unnecessary costs to the Medicare Trust Fund. (OEI-04-97-00391)

Use of Universal Product Numbers for Medical Equipment and Supplies

A Universal Product Number (UPN) can be used universally as the key identifier on each inventory unit for DME and supplies. It can also be used as the key identifier to communicate product information among all trading partners in the supply chain. In a study of the health care industry's use of UPNs, OIG found that they are currently used by some hospitals, distributors and manufacturers. Most industry members agree that UPNs might be of value to Medicare by allowing for specific identification of the product being claimed and providing more efficient edits. They would also aid in fraud and abuse detection.

However, OIG concluded that before UPNs can be used by the Medicare program, there are a number of impediments that must be overcome: a standard national data repository does not currently exist; in those databases that do exist, there is insufficient detail for full identification of product equivalencies; and UPNs are not assigned to all medical equipment and supplies. Further, some manufacturers have concerns about their responsibility to assign these numbers, and HCFA currently lacks authority to appropriately control the system.

The OIG concluded that, in order for UPNs to be used by Medicare, it will be necessary to address the impediments identified; methodically implement steps in utilizing UPNs and conduct periodic assessment of their viability; involve all major players fully in the process; and provide adequate funding for planning and implementing the program. (OEI-07-99-00230)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Federal health care programs are billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. During this reporting period, OIG obtained settlements and convictions of unscrupulous DME suppliers for a variety of schemes as demonstrated by the following examples:

- In Ohio, a DME company owner was sentenced for conspiracy to commit mail fraud and conspiracy to commit money laundering to 70 months imprisonment, payment of \$15.1 million in restitution and 3 years supervised release. The owner previously pled guilty to charges of

defrauding Medicare through a multimillion dollar DME fraud scheme in which he billed the program for urinary incontinence supplies not provided. In actuality, he provided diapers, bed pads and other supplies not covered by Medicare. Additionally, a jury convicted the DME company's former vice-president of corporate affiliates, of conspiracy to commit mail fraud, mail fraud and conspiracy to commit money laundering. She participated in this scheme to defraud Medicare by using improper billing codes for diapers and skin care supplies, in order to receive reimbursement. To hide the scheme from Medicare, she altered certificates of medical necessity, billing codes, amounts billed and numbers indicating the amount of supplies provided.

- Two Illinois DME company owner/operators were sentenced for their roles in a scheme to defraud Medicare. The scheme, which mainly targeted nursing homes, involved billing Medicare for reimbursable female urinary collection devices when they actually provided beneficiaries with noncovered adult diapers. One was sentenced to 40 months imprisonment, 3 years supervised release, payment of \$4.9 million in restitution and an \$8,400 fine. The other was sentenced to 22 months imprisonment, 3 years supervised release, payment of \$7.7 million in restitution and a \$12,600 fine. A third DME company owner previously agreed to pay the Government \$188,897 and was sentenced for his part in the Medicare fraud scheme.
- As the result of a multidistrict health care investigation conducted jointly with the FBI, a DME company owner was sentenced in Louisiana to 41 months imprisonment and \$7.5 million in restitution for conspiracy in connection with filing false Medicare claims. The owner defrauded Medicare by submitting false claims for medically unnecessary urological supplies and by falsely representing their point of sale.
- A Texas dentist was sentenced to 87 months incarceration, 3 years supervised release and ordered to pay \$1.1 million in restitution and an assessment of \$3,650. The dentist had been convicted of 73 counts of false claims, mail fraud and money laundering. In 1992 and 1993, he owned and operated a DME company that billed Medicare \$1,289 apiece for orthotic body jackets when the product he actually supplied was a vinyl-covered, wheelchair cushion manufactured in an automobile upholstery shop at a cost of \$45.
- An Illinois man was sentenced for mail fraud to 18 months incarceration, 3 years probation, participation in a mental health treatment program upon his

release from prison and payment of \$447,271 in restitution. The investigation, which focused on both the man and his DME company, revealed that he used improper billing codes to submit false claims to Medicare. The claims sought reimbursement for expensive, motorized, power wheelchairs when he actually provided beneficiaries with either less expensive, power operated scooters or no equipment at all. From 1995 through 1998, the man improperly received \$447,271 in Medicare reimbursements through the DME fraud scheme.

- A California man was sentenced to 46 months imprisonment, 3 years supervised release and ordered to pay \$107,973 in restitution and a \$4,700 special assessment. The sentence resulted from a criminal trial in which he was convicted on 49 counts of wire fraud and 55 counts of false statements. He and another individual were co-owners of two DME companies that billed for medically unnecessary lymphedema pumps and for pumps never delivered. A citizen of another country, the other co-owner fled the country following his indictment in 1997. Recently arrested when attempting to reenter the United States, he faces charges of conspiracy and false statements contained in the indictment. A sales representative also involved in this scheme previously pled guilty and was sentenced for defrauding Federal health care programs.
- The owner of an oxygen testing business in Florida was sentenced for conspiracy to defraud the Medicare program via mail fraud. His sentence included 10 months imprisonment, 3 years supervised release and payment of \$19,083 in restitution. The owner illegally received cash payments in return for falsified beneficiary blood oxygenation results. He represents the fourth and final individual to be sentenced for his part in this scheme.

Transportation Fraud

Common Medicare and Medicaid fraud schemes associated with transportation and ambulance companies involve the submission of claims for transporting patients to a hospital when the patients are really taken to other facilities for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as a group and falsely claiming reimbursement for ambulatory patients. The following examples of cases involving transportation fraud were resolved during this reporting period:

- Three related Chicago-area ambulance companies and their owners settled allegations that they defrauded the Illinois Medicaid program by seeking reimbursement for transportation that was not medically necessary and/or not supported by required documentation. The defendants will pay over \$350,000 under the terms of the settlement. They will also forego any right

to appeal an additional amount in suspended or withheld claims. The defendants will be permanently excluded from Federal health care programs. This case was part of a joint investigation by OIG, the FBI and the Illinois Medicaid Program called Operation Transport.

- In another Operation Transport case, the owner of a medical transportation company was convicted in a jury trial for submitting claims to Medicare and Medicaid for transportation that was not medically necessary, for fabricating records and for services not rendered. The owner was sentenced to 41 months imprisonment, 2 years of supervised release, and ordered to pay over \$500,000 in criminal restitution. She also consented to a civil judgment in excess of \$1 million to resolve her liability under the False Claims Act. She will be excluded from Federal health care programs.
- A California woman was sentenced for her role in the fraudulent Medicare billing scheme of an ambulance company. She was sentenced to 18 months incarceration, 3 years supervised release and payment of \$1,262 in restitution. In 1998, a Federal jury convicted the woman of three counts of false claims. Previously, the defendant's mother was also sentenced based on her conviction in the same 1998 trial. The mother was sentenced to 1 year and 1 day in custody, 3 years supervised release and payment of \$1,262 in restitution. The women and the company submitted Medicare claims for medically unnecessary ambulance trips; the company transported virtually all Medicare patients by ambulance, regardless of their medical condition.

Federal and State Partnership: Joint Audits of Medicaid

One of OIG's major initiatives has been to work more closely with State auditors in reviewing the Medicaid program; the Partnership Plan was developed to foster these joint review efforts and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 23 States. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in identifying potential program savings of \$173.7 million, of which over \$39 million in Federal and State overpayments has been recovered.

A. Kentucky

During this reporting period, a partnership report on Medicaid reimbursement for clinical laboratory tests in Kentucky was issued. The State auditors found that Kentucky did not have adequate procedures or controls to ensure that such reimbursement did not exceed amounts allowed by the Medicare program, as required by the State Medicaid manual. As a

result, the auditors estimated that the State made potential overpayments of about \$2.3 million (\$1.6 million Federal share) to providers during CYs 1994, 1995 and 1996.

The State auditors recommended that the State review, add and improve the Medicaid management information system's computer edit controls that identify improperly billed laboratory tests; update the provider manuals and billing instructions to reflect Medicaid bundling and duplicate payment requirements; recover the \$2.3 million overpayments and make adjustments for the Federal share of Medicaid funds. The State generally agreed with the recommendations. (CIN: A-04-98-01185)

B. Florida

Along with the State Auditor General, OIG reviewed 2 statistical samples of 100 payments each from CY 1996 to determine the appropriateness of State Medicaid payments for services provided to dually eligible Medicare HMO beneficiaries. The OIG found that Medicare beneficiaries who were also eligible for Medicaid received medical services and drugs that should have been covered by a Medicare HMO but were submitted to and paid for by the State Medicaid fee-for-service program. The erroneous payments occurred because the State did not properly utilize Medicare coverage data to identify beneficiaries who were enrolled in Medicare HMOs.

The OIG recommended that Florida recover \$4.7 million (\$2.6 million Federal share) in unallowable payments from one HMO, and recover the specific overpayments identified and review the balance of the sampling universe to identify the liability of each of the other 50 HMOs and recover additional overpayments; OIG estimates these overpayments to be \$11.2 million (\$6.2 million Federal share). Further, OIG recommended that the State review HMO data for prior and subsequent years to determine if Medicare HMOs had liability for Medicaid payments. The State generally agreed with OIG's findings and recommendations. (CIN: A-04-97-01168)

Mandatory Managed Care: Medicaid Mental Health Services

An OIG review looked at Medicaid mental health programs in seven States that were among the first to convert from fee-for service to mandatory managed care. Representatives of those seven States reported that mandatory managed care allowed them to offer more specialized and creative outpatient services. State respondents also said that overall use of mental health services increased. However, the impact on beneficiaries was not quantified due to lack of outcome measurement systems. Other stakeholders expressed concern that shorter lengths of stay and increased readmission rates may indicate that persons with serious mental illnesses are being released from inpatient care prematurely.

State respondents reported reduced costs. However, OIG found that savings from managed care operations were not always used to improve mental health services. Access to care is

more limited for children than it is for adults, and responsibility for children's mental health care is fragmented among multiple State agencies. However, some States have used interagency agreements to improve coordination of care and access to services. To improve access, States eliminated copayments and encouraged liberal prior authorization policies. (OEI-04-97-00340; OEI-04-97-00344; OEI-04-97-00343)

Medicaid Fraud

At present, 47 States and the District of Columbia have established Medicaid fraud control units (MFCUs). The MFCUs conduct investigations and prosecute providers charged with defrauding the Medicaid program, or persons charged with patient abuse and neglect. As required by the Omnibus Budget Reconciliation Act of 1993, three States -- Nebraska, North Dakota and Idaho -- have sought and received waivers from the requirement that all States operate MFCUs.

During FY 2000, OIG is providing oversight and administering approximately \$95.1 million in funds granted by HCFA to the MFCUs to facilitate their mission.

Although most Medicaid fraud cases are investigated by the MFCUs, OIG works with the units and/or other law enforcement agencies on such cases as well. The following instances of OIG's successful efforts in Medicaid fraud cases bear noting:

- As the result of a joint investigation with the Maryland Medicaid Fraud Control Unit, an ambulance company owner was sentenced to 5 years incarceration and payment of \$245,000 in restitution for Medicaid fraud. In addition, his ambulance company must pay \$100,000 in restitution. The individual operated four ambulances and four wheelchair vans in Maryland. During a 2-year period, he routinely provided wheelchair van services to dialysis patients but billed Medicare and Medicaid for providing ambulance services. He also transported ambulatory and wheelchair bound patients to noncovered, freestanding dialysis centers and billed as though the patients were stretcher bound; transported multiple patients in a single ambulance trip; and billed for ambulance transportation not provided.
- A Missouri hospital and an entity supplying physicians and billing services for those physicians' services at the hospital, agreed to pay the Government \$330,000 to settle a False Claims Act lawsuit against them. The Government alleged that the defendants improperly billed 200 specific Medicaid claims for prenatal and newborn delivery services by misidentifying the provider of the service. The Government also alleged that unsupervised residents, interns and/or nurses actually provided these services. The defendants improperly billed these services under the individual provider number of an attending physician of the month, whether

or not he or she actually provided the service. In addition to the total settlement amount, OIG also imposed comprehensive, 5-year corporate integrity agreements on both defendants.

- A man with two prior felony convictions was sentenced for Medicaid fraud to 1 year and 7 days incarceration (with the year suspended) and 1 year probation. He and another individual, sentenced earlier for Medicaid fraud, were indicted for conspiracy and theft from the Medicaid program. Following their indictment, the men attempted to avoid arrest and prosecution by frequently moving. In August 1999, at the request of the Washington State MFCU, law enforcement agents with OIG, the FBI and the county sheriff's department located and apprehended them. Their arrests occurred in conjunction with an ongoing, multiagency effort, including both the Washington and Oregon State MFCUs, to apprehend Medicaid fraud subjects once indicted.

**Public Health Service
Operating Divisions**

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

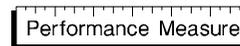
Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) operating divisions (OPDIVs) represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These independent OPDIVs within the Department include: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, biological products and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel, and other health resources and services; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Healthcare Research and Quality (AHRQ), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

The Office of Inspector General (OIG) has concentrated on a variety of public health programs and issues such as biomedical research funding, substance abuse, health services to Indians, drug approval processes and community health center programs. The OIG has looked at the regulation of drugs, foods and devices, and explored the potential for improving these activities through user fees. The OIG has conducted audits of colleges and universities which annually receive substantial research funding from the Department, as well as audits of the financial statements and operations of the PHS OPDIVs. The OIG continues to examine policies and procedures throughout the agencies to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include preaward and recipient capability audits. This oversight work has provided valuable

recommendations to program managers for strengthening the integrity of agency policies and procedures.

Food and Drug Administration's Handling of Adverse Drug Reaction Reports



A critical part of FDA's mission is to monitor the safety of drugs that have been approved for marketing. This effort involves evaluating reports of adverse drug reactions (ADRs) and then taking appropriate regulatory action. By congressional request, OIG reviewed FDA's management of reported ADRs, and identified a number of procedural deficiencies in the current process and recommended ways to make the postmarketing efforts at FDA more effective.

To ensure that prompt and appropriate regulatory action is taken by FDA in response to reported ADRs, OIG recommended that the agency more effectively coordinate its post-market drug risk assessors and review divisions through the development of new policies and procedures. The OIG further recommended that FDA develop and implement a quality control system to ensure that signals of serious, yet unrecognized drug-associated adverse reactions that might indicate a public health problem are not overlooked; develop and apply methodologies to quantify the extent and scope of the ADR problem with the goal of reducing the occurrences of serious, preventable ADRs; encourage greater interactive reporting of serious ADRs and product problems by health professionals directly to FDA by telephone or Internet to ensure accuracy and timeliness; coordinate with the Health Care Financing Administration to require hospitals to report all serious, unexpected ADRs directly to FDA as a condition for participation in Medicare and Medicaid; and ensure that FDA has sufficient resources to effectively monitor the safety of the increasing number of marketed drugs. The FDA agreed with OIG's recommendations and stated that it was taking or planning to take actions to strengthen the ADR reporting and handling process. (CIN: A-15-98-50001)

Impact of State Children's Health Insurance Program on Changing Service Delivery of Federal Health Centers: Six Case Studies

Enacted as part of the BBA of 1997, SCHIP was a response to increasing numbers of children lacking health coverage. The legislation gives States flexibility to institute a separate health insurance program, expand Medicaid eligibility or combine these approaches. Federally funded health centers have been major safety-net providers for low income children since the 1960s. Such centers were often the primary health care source for growing numbers of children without health insurance when SCHIP was passed. The HRSA and the Assistant Secretary for Planning and Evaluation expressed interest in looking at the involvement of these centers in the early implementation of SCHIP.

In this study, OIG examined the experience of six federally funded health centers during their States' early implementation of SCHIP and/or concurrent Medicaid expansions. With their tradition of serving low income children, OIG found that these centers have considerable potential for supporting the goals of SCHIP. They possess great aptitude for outreach and enrollment due to the level of trust and service they have established in their communities. Recognizing the need to adapt to managed care environments, most centers have assertively joined MCOs or undertaken special developmental efforts, ranging from infrastructure enhancements to creation of entire MCOs. Not surprisingly, transition from cost-based reimbursement continues to be a challenge for centers as they seek to better manage costs and devise appropriate reimbursement formulae within their health plan contracting. (OEI-06-98-00320)

Comprehensive Hemophilia Treatment Centers' Utilization of Public Health Service 340B Drug Pricing Program

Performance Measure

The OIG determined that improvements are needed to ensure that all State Medicaid agencies benefit from the price advantages available to Public Health Service grantees under the PHS 340B drug pricing program. Of the 23 participating hemophilia treatment centers (HTCs) contacted, officials from 6 stated that their entities purchase outpatient drugs at the 340B discount price, but not for their Medicaid beneficiaries. For one selected center, OIG found that the State could achieve annual savings ranging from \$18,395 to \$27,170 per person if it reimbursed the HTC at the 340B discount prices instead of the Medicaid rate.

The OIG recommended that HRSA and the Health Care Financing Administration (HCFA) work together to achieve a fair and equitable resolution of the issues involving the economical purchasing, and subsequent Medicaid billing, of covered drugs by entities participating in the 340B program. Officials in HRSA and HCFA concurred with the recommendation. (CIN: A-01-98-01505)

Exclusions for Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking an education in a health-related field of study. The students are allowed to defer repayment of these loans until after they have graduated and begun to earn an income. Although the Department's Program Support Center (PSC) takes all steps that it can to ensure repayment, some loan recipients ignore their indebtedness.

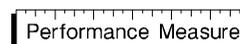
After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period, 154 individuals were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

After being excluded for nonpayment of their HEAL debts, a total of 1,391 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debt. This figure includes the 83 individuals who have entered into such a settlement agreement or completely repaid their debt during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$82 million. Of that amount, \$2.8 million is attributable to this reporting period. The following are examples of some of these settlements:

- A podiatrist in New York entered into a settlement agreement to repay his \$145,000 HEAL debt.
- After being notified that she was excluded as a result of her failure to repay her HEAL debt, a Washington dentist entered into a settlement agreement to repay over \$90,000 in student loans.
- A physician in Idaho entered into an agreement to repay her HEAL debt of over \$156,000.
- A settlement agreement was signed by a Connecticut dentist to repay his HEAL debt of \$137,000.
- In Kansas, a chiropractor entered into a settlement agreement to repay his HEAL debt of over \$123,000.

National Institutes of Health Small Business Innovation Research Program



The Small Business Innovation Research Program, coordinated and administered by the Small Business Administration, was established to stimulate technological innovation, meet Federal research and development needs, and increase private sector commercialization of innovations derived from Federal research and development. Since the program's inception in 1983, NIH has awarded \$1.7 billion in research grants to small businesses.

The OIG found that NIH did not ensure that grantees comply with the requirements to disclose their inventions and patents. As a result, the Government may not be able to claim its rights to inventions and patents developed with NIH funds, or promote the development

and availability of the inventions to the public. In addition, NIH did not have a system in place to track the success of the Small Business Innovation Research Program in meeting a significant objective, the commercialization of research. In response to the draft report, NIH generally agreed with OIG's recommendations and has taken several steps to address these shortcomings. (CIN: A-15-98-00031)

**Administration
for Children
and Families,
and Administration
on Aging**

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The major programs include: Temporary Assistance for Needy Families (TANF), Child Support Enforcement (CSE), Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

With respect to TANF, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

In addition, OIG reviews the Department's programs that serve children, and has issued a number of reports in this area. The OIG reports have focused on ways to increase the efficient use of the program dollar, more effective program implementation, and how to better coordinate program implementation among the Federal, State and local governments.

In 1993, the Congress passed the Government Performance and Results Act mandating Federal agencies to establish strategic planning and to prepare annual performance plans, beginning with a plan for FY 1999. The annual performance plan sets out measurable goals that define what will be accomplished during a fiscal year. The OIG has initiated a review of selected data sources and information collection systems supporting ACF's 1999 performance plan.

The Administration on Aging (AoA), which reports directly to the Secretary, awards grants to States for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive services, nutrition services, education and training, low-cost transportation and health promotion. The OIG has reported opportunities

for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight.

Paternity Establishment: State Use of Genetic Testing

Widespread use of genetic testing has contributed to increases in the number of paternities established in recent years. To obtain information on how States use genetic testing, barriers to its use and strategies to surmount those barriers, OIG surveyed child support agency directors in all States. In addition, in six focus States, OIG surveyed local child support office managers and interviewed local managers and staff during site visits to 24 offices.

The OIG found that States use genetic testing in a large number of paternity cases. However, many mothers and putative fathers have incentives not to test. Other barriers, such as inconvenient testing locations, client fear of needles, and lack of transportation may inhibit the use of genetic testing. The OIG identified some promising strategies to surmount those barriers, but found that they are used only in limited areas of the country.

The OIG recommended that ACF encourage States to give agencies administrative authority to order genetic testing; to use innovative strategies, such as buccal swab (cheek cell) sampling, at local child support offices; and to exercise care in allowing genetic testing in cases in which paternity has already been legally established. The ACF generally agreed with OIG's recommendations. (OEI-06-98-00054)

Paternity Establishment: Role of Vital Records Agencies

In this inspection, OIG found that an overwhelming majority of State vital records agencies believe that paternity establishment has public health benefits and report that they accept, process and record paternity information. Thirty-five States maintain a Statewide database. Local vital records offices in 42 States offer acknowledgment services to parents, but implementation is often not Statewide and the level of service varies considerably. Vital records agencies were concerned that they might not receive paternity information from courts and child support offices, so that birth records within the vital records agencies might be inaccurate and create long-term problems for parents and children. While child support agencies in 34 States rated vital records agencies favorably in the transfer of information, local child support offices in the focus States reported difficulty in retrieving information. The OIG concluded that many State child support and vital records agencies have still not made broad efforts to collaborate, or have abandoned initial efforts.

The OIG recommended that the Office of Child Support Enforcement (OCSE) promote notification of vital records agencies when paternities are established or rescinded, and encourage automatic amendment of the birth record; promote State training of local child support staff on methods of retrieving data from vital records agencies and use of vital records agency information; and encourage States to make training and materials on

acknowledgment procedures created for hospital staff widely available to local vital records agency staff. The ACF concurred with OIG's recommendations. (OEI-06-98-00055)

Child Support Enforcement: Investigations

The United States Attorney General has placed enforcement of the Child Support Recovery Act of 1992 as a top Department of Justice (DOJ) priority. The Act made it a Federal misdemeanor crime for a parent in one State to refuse to pay past due support for a child in another State, when the support has been owed for more than 1 year or exceeds \$5,000. Any subsequent offense is a felony violation. A recent amendment to this Act has created two other felony provisions for the most egregious first time violations.

The OIG has also made the investigation of these matters a high priority. The OIG and OCSE are the sponsors of Project Save Our Children: five multiagency, multijurisdictional investigative task forces whose missions are to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws in the regions covered by the task forces. The task forces are comprised of personnel from the OIG Office of Investigations, U.S. Marshals Service, U.S. Attorneys Offices, DOJ, State and local child support offices, State and local law enforcement, State and local prosecutors, representatives from the judiciary (both State and Federal), and representatives from the corrections and probation offices at both the Federal and State levels.

The task forces are structured to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. There are investigative units in each of the States which conduct the actual investigations. The units work with the State child support offices to identify the cases that the States then refer to the task force. The units also work with prosecutors at State and Federal levels to ensure that the cases worked are those that will be prosecuted in a volume consistent with the resources of those offices.

Central to the task forces are the screening units located in each task force region which are staffed by analysts and auditors from both OIG and OCSE. These units receive the child support cases from the States, conduct preinvestigative analyses of these cases through the use of information databases and then forward the cases to the investigative task force units where they are assigned and investigated. This streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition. As the task forces bring in more law enforcement partners on the State level, the number of cases adjudicated will rise dramatically. At this point, the task force units have received over 1,800 cases from the States. As a result of the work of the task forces, 62 Federal arrests have been executed and 46 individuals already sentenced. The total recovered amount related to Federal investigations is \$1.7 million. There have been 201 arrests on the State level and 194 convictions or civil adjudications to date, resulting in \$7.8 million in restitution.

Two of the five task forces were initiated in 1998 and are headquartered in Columbus, Ohio and Baltimore, Maryland. These task forces cover the Midwest and Mid-Atlantic regions -- with special emphasis on the States of Illinois, Michigan, Ohio, Indiana, Maryland, Virginia, Pennsylvania, Delaware, the District of Columbia and West Virginia. Based on the success of these two initial task forces, three more have become operational in other areas of the country, including the Northeast, Southwest and the West Coast. In the Northeastern task force area, investigative efforts are headquartered in New York City, with special emphasis on the States of New York and New Jersey. For the Southwestern area, headquartered in Dallas, Texas, efforts focus especially on the States of Texas, Louisiana and Oklahoma. Efforts of the West Coast task force area are directed at the States of California, Oregon, Washington and Arizona, with headquarters located in Sacramento, California.

Examples of the Federal arrests, convictions and sentencings resulting from OIG's enforcement work both inside and outside the task force areas during this reporting period include the following:

- In Virginia, a man was sentenced for willful failure to pay a past due child support obligation to the maximum penalty allowable under the statute. The magistrate judge ordered the defendant to pay \$140,405 in restitution, the amount owed in past due support, and to serve 5 years probation. As part of probation, the judge also ordered him to serve 6 months in jail.
- In Texas, a man was sentenced to 5 years probation and payment of \$129,737 in restitution for failure to pay child support. He was also ordered to participate in a drug and alcohol abuse treatment program and a family violence program. The sentence is to commence upon his release from a California prison where he is currently incarcerated for a felony drug conviction.
- Based on an arrest warrant from Arizona, a man entered a guilty plea for failure to pay child support in New Mexico. The court accepted his plea and sentenced him to 5 years probation and payment of \$98,161 in restitution. A successful realtor, the man must pay at least 22 percent of every real estate commission he earns as stipulated by the plea agreement. It is expected that he should be able to pay his past due obligations within the next 5 years.
- Following his convictions on both the Federal and State levels, a prominent New Hampshire physician was ordered to serve 16 months in prison and 3 years probation. He was also ordered to pay \$66,132 in restitution to the Internal Revenue Service and \$5,210 in fines and special assessments. The sentences were based on earlier guilty pleas to failure to pay child support

and Federal tax fraud. As a result of OIG's investigation, he also paid the State \$49,615 toward his child support arrearage in July 1999. In order to avoid his child support obligation, the physician previously fled the State and moved to Belize. Through a joint effort of Federal, State, local and foreign law enforcement authorities, he was located abroad, arrested and transported back to New Hampshire.

- A Colorado missionary pled guilty and was sentenced for failure to pay child support in two separate cases in Virginia. In the first case, the man was sentenced to pay his arrearage of \$44,794 in restitution; he failed to pay any support for two of his children who reside in Virginia since June 1994. In the second case, he was sentenced to pay his arrearage of \$33,715 in restitution for failing to pay any support for his daughter in Virginia over the past 5 years. In accordance with his plea agreements in these cases, he will also serve a probation period of 5 years.
- A chief of police in Wyoming was sentenced to 5 years supervised probation and payment of \$48,934 in restitution for failure to pay child support. As part of a 1987 divorce decree, a Colorado district court ordered him to pay \$900, and later \$1,000, a month in support of his four children. In 1992, he moved from Colorado to Florida to avoid paying his obligation and found employment as a deputy sheriff. In 1993, the State of Florida began child support enforcement proceedings against him, and when the court ordered his wages garnished in 1995, he quit his job and moved to Utah. He frequently moved among several States including Colorado, Tennessee and Wyoming.
- A man pled nolo contendere to failure to pay child support for his children in Louisiana. At the time of his arrest, he owed \$48,900 in support. Since then, he has paid \$20,000 toward his arrearage. Additionally, the judge ordered him to pay \$239 per month to be applied against the remaining child support balance and to make his current child support payments of \$1,600 per month. He was also placed on 5 years supervised probation. In response, he created a web page describing the negative impact of the Government's child support enforcement efforts on his family.
- Following her trial, a magistrate judge found an Ohio woman guilty of failing to pay \$26,231 in child support for her two daughters. She was subsequently placed on 5 years probation and ordered to pay her arrearage in restitution. The court also ordered that she gain and maintain employment and that she attend mental health counseling. In addition, the monies owed in child support will be deducted from her earnings according

to State of Ohio withholding calculations. While working at a university in Mississippi from July 1997 to August 1998, the woman paid no child support. During this period, she resided with her daughter from a previous marriage and paid no rent. Despite her extensive employment history as a paralegal, she has a history of quitting gainful employment after wage withholdings are issued.

During this period, OIG investigations of child support cases nationwide resulted in 72 convictions and court-ordered restitution of over \$3.7 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are often ordered.

Emergency Assistance Program: New York Family Assistance Program

New York retroactively claimed \$13.2 million (\$6.6 million Federal share) in Federal nonparticipating foster care costs for reimbursement under the title IV-A Emergency Assistance (EA) program. The OIG's statistical sample of 100 such claims disclosed that 74 were not allowable for EA reimbursement. Specifically, 72 claims were unallowable because they included services provided outside the 12-month statutory limit for reimbursement, one claim was missing authorization and one claim was for services which were provided after the emergency had ended.

Based on its sample, OIG estimated that at least \$3.6 million (Federal share) of New York's retroactive claim is unallowable. The OIG is recommending a financial adjustment for the \$3.6 million. (CIN: A-02-98-02002)

New York State Foster Care Claims for New York City

This final report estimated, based on a statistical sample, that New York claimed approximately \$40.7 million (Federal share) for foster care claims that did not meet requirements for Federal financial participation. In 9 cases, the claims did not meet physical removal requirements (that the child be physically removed from his prior home within 6 months of court proceedings), and in 108 cases, the State was unable to establish that the children were living in approved, licensed foster care homes.

The OIG referred its projected overpayments to ACF for its review and determination of an appropriate resolution. The OIG also recommended that the State and City develop and implement a comprehensive corrective action plan which ensures compliance with the physical removal eligibility requirement, and more important, takes immediate and effective corrective action to ensure that foster care children are only placed in approved homes. (CIN: A-02-97-02002)

Foster Care Maintenance Payments to For-Profit Child Care Providers in Illinois

The OIG found that the Illinois claims processing system was not effective in excluding payments to for-profit child care providers ineligible for Federal financial participation (FFP). Section 472 of the Social Security Act requires that foster care payments be made on behalf of eligible children to nonprofit child placement agencies and child care institutions. During the period July 1992 through March 1999, the State improperly claimed nearly \$11.3 million (Federal share) for child care payments to for-profit child placement agencies and institutions.

The OIG recommended that ACF work with the State to resolve these improperly claimed payments and that the State implement controls to preclude the claiming of FFP for foster care payments made to for-profit child care providers. (CIN: A-05-99-00004).

Retroactive Adjustments Filed Under the Title IV-E Foster Care Program: Massachusetts

The objective of this review was to determine whether retroactive adjustments to foster care maintenance claims were adequately supported and complied with Federal eligibility requirements. Based on a statistical sample, OIG estimated that documentation in the case files for 17,229 retroactive adjustments for FYs 1994 to 1997 did not support all Federal reimbursement requirements. Massachusetts did not have adequate controls in place to ensure that procedures were followed in obtaining judicial determinations that remaining at home was not in the child's best interest and reasonable efforts had been made to prevent the child's placement with the State. Controls over maintaining and locating case files and pertinent court documents were also insufficient. As a result of these problems, OIG projected overpayments of nearly \$21.8 million (\$10.9 million Federal share). The OIG referred the projected overpayments to ACF for its review and determination of an appropriate resolution.

In addition, the OIG's reconciliation of supporting documents to quarterly expenditure reports identified \$3.7 million (\$1.85 million Federal share) in overpayments. As OIG recommended, the State refunded the \$1.85 million. (CIN: A-01-98-02505)

Adoption and Foster Care Analysis and Reporting System

The Government Performance and Results Act of 1993 mandated that Federal agencies prepare performance plans, including measures used to assess performance. The ACF performance measures pertaining to children in foster care and children adopted under the auspices of a State welfare agency are based on data from the Adoption and Foster Care Analysis and Reporting System (AFCARS). States collect and transmit case management information to ACF through this system.

The OIG assessed the reliability of the AFCARS data submitted by Missouri and Texas for the first half of FY 1999. While OIG found some errors in the information from both States, these errors did not affect the data used to develop ACF's performance measures or were not pervasive enough to affect reported measures. However, as a result of a problem in the data transfer process in Missouri, ACF received incorrect information on children with disabilities -- information that ACF uses for other program management purposes. Both Missouri and Texas concurred with OIG's findings and recommendations, and are making system adjustments to prevent future errors. (CIN: A-07-99-01040; CIN: A-06-99-00053)

Head Start, Temporary Assistance to Needy Families and Child Care Needs Assessments

Federal legislation requires that both TANF and Head Start agencies assess participants' needs to help them address barriers to employment and self-sufficiency. There is no formal requirement that Child Care and Development Fund (CCDF) child care programs or Child Care Resource and Referral (CCRR) agencies who administer subsidies assess family needs or offer support services.

In an inspection conducted in six communities, OIG found that all Head Start grantees used needs assessment to help low-income families move toward self-sufficiency. The TANF offices visited focused almost exclusively on vocational needs. Individual child care programs did not assess family needs, though some may have made informal assessments and referred families to needed services. The OIG found a lack of coordination among the Head Start grantees, TANF agencies, CCRR agencies and child care providers visited.

In order to maximize efforts to help families reach and maintain self-sufficiency, OIG recommended that ACF explore strategies that encourage and facilitate coordination between agencies around needs, referral and provision of services for families; and encourage Head Start grantees, TANF offices and child care programs to increase parent awareness about the resources they and other community agencies provide. (OEI-05-98-00540)

Technical Assistance for Quality Child Care: Regional Office Perspectives

The Personal Responsibility and Work Opportunity Act of 1996 repealed a number of child care programs and created a single, integrated Child Care and Development Block Grant for low-income families. The ACF contracts with outside entities to provide technical assistance funded through this grant. This includes the coordination and support of regional and national conferences, national workgroups, leadership forums, activities to improve health and safety, audio conference calls and creation of the National Child Care Information Center. In 1997, ACF augmented its technical assistance capabilities by creating the Child Care Technical Assistance Network. The ACF Child Care Bureau and regional offices play

important roles in the provision of technical assistance to State, Territory and Tribal grantees. The regional offices are in a pivotal position to observe technical assistance and have knowledge of regional needs which serve as a bridge between national and local policy.

The OIG found that regional office staff value the resources available through the Child Care Technical Assistance Network. However, based on their responses, OIG recommended that ACF enhance their program by: providing regional offices with additional information about technical assistance involving network project expectations, contractor responsibilities and ongoing work; maintaining and improving effective technical assistance formats; and focusing technical assistance on issues suggested by regional office staff as critical. The ACF agreed with OIG's recommendations and described various improvements in their technical assistance initiatives. (OEI-07-97-00422)

24-Month Performance Data for Administration on Aging's Health Care Fraud Control Grants

Performance Measure

The OIG has developed performance measures for, and continues to monitor, AoA's two health care fraud control grants. For the 12 senior Medicare patrol projects, OIG noted a number of substantial increases in the performance data since the last 6-month reporting period. The total number of trainers almost doubled, from 3,700 to 6,300, due primarily to efforts in Minnesota and New York. Further, OIG noted that the total number of beneficiaries educated almost doubled, from 61,000 to 116,000, due to increases in virtually all States. Also, while the total of funds recouped remained relatively constant, the number of complaints referred for follow-up and resulting in action both increased 50 percent to 601 and 138, respectively.

Regarding the 18 projects funded by the Health Insurance Portability and Accountability Act of 1996, a comparison to data collected from the previous reporting period revealed the following: trainers increased, from 8,511 to 9,781; beneficiaries educated more than doubled, from 10,727 to 25,556; complaints received increased by half, from 6,318 to 9,852; and Medicare funds identified for recoupment were \$1,400. (OEI-02-97-00523; OEI-02-97-00524)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities.

The Program Support Center (PSC), a separate operating division (OPDIV) within the Department of Health and Human Services (HHS), provides overall direction for departmental administrative activities as well as common services such as human resources, financial management, administrative operations and information technology. The Office of the Assistant Secretary for Management and Budget (ASMB) is responsible for the development of the HHS budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, and payment of HHS grants and contracts. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is cognizant agency to audit the majority of the Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG became responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

The OIG's work in departmental administrative activities and Governmentwide oversight focuses principally on financial statement audits, financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Financial Statement Audit of the Department for Fiscal Year 1999

Performance Measure

As required by the Government Management Reform Act of 1994, OIG audited the departmentwide consolidated and combined financial statements for FY 1999, which include the consolidated balance sheet of the Department, the related statements of net cost and changes in net position, and the combined statements of budgetary resource and financing. This audit encompassed individual audits of nine OPDIVs' financial statements.

The audit report, which appears in the Department's Accountability Report for FY 1999, gives an unqualified opinion on the FY 1999 statements. This means that the Department successfully resolved previously reported opinion issues and that the FY 1999 statements reliably presented departmental financial information. The Department has worked diligently to achieve this important milestone.

While a clean audit opinion assures financial statement users that the information is reliable and fairly presented, it does not provide an assurance on the effectiveness and efficiency of the financial systems used to prepare the statements. The OIG continues to cite as a material internal control weakness the deficiencies in the Department's financial systems and reporting. The lack of a unified, integrated financial management system and the OPDIVs' failure to routinely reconcile and analyze accounts throughout the year led to major adjustments to OPDIV financial statements as late as February 2000, nearly 5 months after the close of the fiscal year. Continuing problems in controls over Medicare accounts receivable and Medicare electronic data processing were also reported as material weaknesses.

The Department generally agreed with OIG's recommendations for improvements. (CIN: A-17-99-00002)

Nonfederal Audits

The OMB Circular A-133 establishes the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 2000, OIG's National External Audit Review Center (located in Kansas City) reviewed about 1,900 reports that covered over \$800.2 billion in audited costs. Federal dollars covered by these audits totaled \$229.1 billion, about \$103.7 billion of which was HHS money.

The OIG's oversight of the nonfederal audit activity not only provides Department managers with assurances about the management of Federal programs, but also identifies any significant areas of internal control weakness, noncompliance and questioned costs that require formal resolution by Federal officials.

A. Office of Inspector General's Proactive Role

The OIG has taken the following steps in the nonfederal area to ensure adequate coverage of the Department's programs and provide for greater utilization of the data obtained:

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS programs. These problems are brought to the attention of departmental management who can take steps to improve program administration. In addition, OIG profiles nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems.
- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor. The OIG actively assists the National Association of State Auditors, Controllers and Treasurers in performing peer reviews of State audit organizations.
- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679). In addition, OIG offers various training; for example, formal training was provided to certified public accountant societies and State auditor staffs on issues related to Circular A-133.
- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.
- The OIG led the revision of the Initial Review Guide and Quality Control Review Guide issued by the President's Council on Integrity and Efficiency and used for quality assurance.

B. Quality Control

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the quality of the nonfederal reports received and the audit work that supports selected reports. Uniform procedures are used to review nonfederal audit reports to

determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,948 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,860
Reports issued with major changes	31
Reports with significant inadequacies	<u>57</u>
Total audit reports processed	1,948

The 1,948 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$9 million as well as 5,234 recommendations for improving management operations. In addition, these audit reports provided information for 87 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

The tables and schedules below summarize actions taken on OIG recommendations to recover funds or to put them to better use.

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of violation of law, regulation, grant conditions, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and section 5 of the Inspector General Act. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 73).

	<u>Number</u>	<u>Dollar Value</u>	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	411	\$292,274,000	\$22,039,000
B. Which were issued during the reporting period	<u>165</u>	<u>\$150,424,000</u>	<u>\$73,796,000</u>
Subtotals (A + B)	576	\$442,698,000	\$95,835,000
Less:			
C. For which a management decision was made during the reporting period ² :	130	\$46,086,000	\$823,000
(i) dollar value of disallowed costs ^{3,4}		\$40,471,000	\$246,000
(ii) dollar value of costs not disallowed		\$5,615,000	\$577,000
D. For which no management decision had been made by the end of the reporting period	446	\$396,612,000	\$95,012,000
E. For which no management decision was made within 6 months of issuance ⁵	284	\$238,795,000	\$21,268,000
See Appendix D for footnotes.			

B. Funds Put to Better Use

The following chart summarizes reports which include recommendations that funds be put to better use through cost avoidances, budget savings, etc.

TABLE II OFFICE OF INSPECTOR GENERAL REPORTS WITH RECOMMENDATIONS THAT FUNDS BE PUT TO BETTER USE		
	<u>Number</u>	<u>Dollar Value</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	29	\$1,466,248,000
B. Which were issued during the reporting period	<u>10</u>	<u>\$3,192,711,000</u>
Subtotals (A + B)	39	\$4,658,959,000
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action ²	7	\$937,462,000
(b) based on proposed legislative action	<u>0</u>	<u>0</u>
Subtotals (a+b)	7	\$937,462,000
(ii) dollar value of recommendations that were not agreed to by management	<u>2</u>	<u>\$3,186,540,000</u>
Subtotals (i + ii)	9	\$4,124,002,000
D. For which no management decision had been made by the end of the reporting period ³	30	\$534,957,000
See Appendix D for footnotes.		

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigations and other activities highlighted in this and previous semiannual reports. Recommendations made by OIG for legislative and regulatory change can be found throughout this semiannual report.

B. Regulatory Development Functions

The OIG is responsible for the development and promulgation of a variety of sanction regulations addressing civil money penalty (CMP) and program exclusion authorities administered by the Inspector General, as well as safe harbor regulations related to the anti-kickback statute. Among the regulatory initiatives promulgated during this reporting period were:

- Final regulations establishing the new Healthcare Integrity and Protection Data Bank (HIPDB)(64 FR 57740; October 26, 1999).
- Final regulations that clarified the initial OIG safe harbor provisions and established additional safe harbor provisions under the anti-kickback statute (64 FR 63518; November 19, 1999).
- Interim final regulations that set forth a statutory exception to the anti-kickback statute for shared risk arrangements (64 FR 63504; November 19, 1999).
- Proposed regulations designed to exempt the new HIPDB system of records from certain provisions of the Privacy Act (64 FR 57619; October 26, 1999).

In addition, during this period, the Inspector General signed and the Secretary approved the following rules that are awaiting final clearance by the Office of Management and Budget:

- Final regulations addressing revised OIG CMP authorities resulting from Public Law 104-191, the Health Insurance Portability and Accountability Act.
- Proposed regulations that would set forth a new safe harbor to protect arrangements involving hospitals that replenish drugs and medical supplies used by ambulance providers when transporting emergency patients to hospitals.

- Proposed regulations that would establish a CMP safe harbor to protect payment of Medicare supplemental insurance and Medigap premiums for end-stage renal disease dialysis patients.

Also, during this period, OIG prepared and published a variety of Federal Register notices that addressed the ongoing development of compliance program guidances, special advisory bulletins and other related OIG initiatives. These included:

- An OIG special advisory bulletin on the effect of exclusion from participation in Federal health care programs (64 FR 52791; October 7, 1999).
- An OIG special advisory bulletin addressing requirements of the patient anti-dumping statute (64 FR 61353; November 10, 1999).
- Publication of final OIG compliance program guidance for hospices (64 FR 54031; October 5, 1999) and for Medicare+Choice organizations offering coordinated care plans (64 FR 61893; November 15, 1999).
- Publication of final OIG compliance program guidance for nursing facilities (65 FR 14289; March 16, 2000).
- A solicitation notice for developing new, and modifying existing, safe harbors under the anti-kickback statute, and for developing new OIG special fraud alerts (64 FR 69217; December 10, 1999).

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at seven hearings during this 6-month period, principally on health care fraud and abuse issues. On several occasions, the testimony concerned OIG recommendations which, if implemented, could produce significant annual savings to the Government. These recommendations are contained in the OIG Cost Saver Handbook, also known as the Red Book. The hearing process offers OIG the opportunity to meet its statutory obligation of keeping the Congress informed of its work with regard to the effective and efficient operation of Department programs. The OIG continues to track all relevant congressional hearings and pending legislation relative to a wide range of issues.

Employee Fraud and Misconduct

The OIG has oversight responsibility for the investigation of allegations of wrongdoing by Department employees when it affects internal programs. Most of the persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities, as illustrated by the following example:

- In the District of Columbia, a former National Institutes of Health (NIH) employee was sentenced to 6 months home detention, 5 years supervised probation, mandatory participation in a drug aftercare program and payment of \$40,000 in restitution for making false statements to obtain compensation. In October 1995, the employee allegedly suffered a job-related injury after which he filed multiple claims with the Department of Labor, Office of Worker's Compensation, stating that he was unable to perform his duties as an NIH technician. Investigation revealed, however, that he worked for at least three different employers while claiming benefits under the Federal Employee's Compensation Act.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 205 successful criminal actions. Also during this period, 575 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 241 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$968 million was ordered or returned as a result of OIG investigations during this semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Appendices

APPENDIX A

Savings Achieved through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections October 1999 through March 2000

The following schedule highlights savings resulting from Office of Inspector General (OIG) efforts to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. These achievements depend greatly on the contributions of others, such as OIG's partners within the Department and elsewhere. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management in response to OIG audits, investigations and inspections, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance or bonds.

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates for a 5-year budget cycle. Consistent with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Omnibus Consolidated and Emergency Supplemental Appropriation Act (OCESAA) of 1998 and the Balanced Budget Refinement Act (BBRA) of 1999. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to \$8,447.8 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Reforming Medicaid Disproportionate Share Payments:		
Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073; CIN: A-04-92-01025)	Section 4721 of the BBA of 1997 reformed disproportionate share payments under State Medicaid programs by placing limitations on Federal financial participation.	\$2,090
Medicare Part A Payments for Skilled Nursing Facilities:		
Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and a legislative recommendation should be developed to prohibit entities other than the skilled nursing facility (SNF) from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment system (PPS) and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; CIN: A-17-95-00096; CIN: A-14-98-00350)	Section 4432 of the BBA of 1997 (as amended by the Balanced Budget Refinement Act of 1999) required a PPS for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.	1,850

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Secondary Payer Extensions: Establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer based coverage available. (OEI-07-90-00760; OEI-03-90-00763; CIN: A-10-86-62016; CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00391; CIN: A-14-94-00392)</p>	<p>The database capacity was achieved through the authorization of a data exchange between the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA) and between the Internal Revenue Service (IRS) and HCFA. Section 4631 of the BBA of 1997 permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.</p>	<p>\$1,790</p>
<p>Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The HCFA should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (CIN: A-09-91-00070; CIN: A-07-95-01127)</p>	<p>Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.</p>	<p>1,140</p>
<p>Medicare Payments for Oxygen: The HCFA should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711, OEI-03-91-001710)</p>	<p>Section 4552(a) of the BBA of 1997 reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.</p>	<p>400</p>
<p>Medicare Laboratory Reimbursements: In July 1989, OIG recommended that HCFA take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that HCFA seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace. In a January 1996 follow-up, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although the Omnibus Budget Reconciliation Act (OBRA) of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that HCFA periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for the same clinical laboratory services. (OAI-02-89-01910; CIN: A-09-89-00031; CIN: A-09-93-00056)</p>	<p>Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002.</p>	<p>400</p>

OIG Recommendation	Implementing Action	Savings in Millions
<p>Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)</p>	<p>Section 4551 of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002, and simplified the process used to reduce inherently unreasonable prices by 15 percent.</p>	\$200
<p>Medicare Home Health Care Services: The HCFA should revise Medicare regulations to require that the treating physician establish the plan of care and specifically prescribe the type and frequency of home health services needed. (CIN: A-04-94-02087)</p>	<p>Effective February 1995, Medicare regulations require that a beneficiary be under the care of a physician who establishes the plan of care and that the physician's orders for services in the plan of care specify the medical treatments to be furnished, the discipline to furnish the services and their frequency.</p>	199.2
<p>Medicare Payments to Hospitals for Bad Debt: The HCFA should seek legislative authority to modify the bad debt payment policy. (CIN: A-14-90-00039)</p>	<p>Section 4451 of the BBA of 1997 reduced bad debt payment to providers to 75 percent during FY 1998, 60 percent during FY 1999 and 55 percent in later years.</p>	120
<p>Medicare Payments for Prescription Drugs: The HCFA should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)</p>	<p>Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.</p>	110
ADMINISTRATION FOR CHILDREN AND FAMILIES		
<p>\$50 Child Support Disregard in the Child Support Enforcement Program: The \$50 disregard provision, which allowed the first \$50 collected from absent parents to be turned over to the family and not counted against Aid to Families with Dependent Children (AFDC) benefits, did not provide the AFDC family with any incentive to cooperate more fully with child support officials in locating the absent parent and should be eliminated. (CIN: A-02-86-72606)</p>	<p>Section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminated the authority which allowed the recipient to keep the first \$50 of child support collected in a month.</p>	139

Other	Implementing Action	Savings in Millions
VARIOUS OPERATING DIVISIONS		

Results of Investigations:

In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.

The operating division takes action based on the results of the OIG investigation to suspend or terminate payments to the offending individual or entity.

\$9.6

APPENDIX B

Unimplemented Office of Inspector General Recommendations to Put Funds to Better Use

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the Administration through legislative or regulatory action, or policy determinations by management. (In many cases, these recommendations are beyond the direct authority of the departmental operating division.) It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal medical assistance percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041)	The HCFA did not agree with the recommendation, and no legislative proposal was included in the President's current budget.	\$4,100
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that this approach has merit and could be pursued on an experimental basis at this time.	2,040
Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's FY 2001 budget. Also, HCFA did not agree with the recommendation to make Medicare the secondary payer.	1,559

OIG Recommendation	Status	Savings in Millions
<p>Clinical Laboratory Tests: Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-93-00056)</p>	<p>The HCFA agreed with the first recommendation but not the second. The Balanced Budget Act (BBA) of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002; the budget would increase payments at Consumer Price Index-Urban minus 1 percentage point for 2003 through 2005. The FY 2001 budget includes a proposal to restore 20 percent coinsurance for clinical diagnostic laboratory tests. Payments would be reduced for four high-volume laboratory tests in another FY 2001 legislative proposal.</p>	\$1,130*
<p>Excessive Medicare Payments for Prescription Drugs: The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)</p>	<p>The BBA of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price. Additional corrective action is warranted and called for in the President's 1999 and 2000 budget and legislative programs. The FY 2001 budget proposes paying for Medicare-covered drugs at 83 percent of the average wholesale price (AWP).</p>	1,000
<p>Reduce Hospital Capital Costs: Determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)</p>	<p>The HCFA did not agree with the recommendation. Although the BBA of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.</p>	820

*This savings estimate would result from the copayment; the savings estimate for panels has yet to be determined.

OIG Recommendation	Status	Savings in Millions
<p>Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and/or seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)</p>	<p>The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken. However, pursuant to section 4711 of the BBA of 1997, the Secretary shall conduct a study on the effect on access to, and the quality of services provided to beneficiaries of the rate-setting methods used by States.</p>	\$683
<p>Modify Payment Policy for Medicare Bad Debts: The OIG presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p>	<p>The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provides for some reduction of bad debt payments to providers. The President's FY 2001 budget proposes to reduce the percentage (from 55 percent to 45 percent) that Medicare pays for bad debts and to extend this policy to providers beyond hospitals. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	340
<p>Flexible Benefit Plans: The value of flexible benefit plans should be included in the definition of wages for the hospital insurance portion of the Federal Insurance Contributions Act. (CIN: A-05-93-00066)</p>	<p>While HCFA agreed with the recommendation and has submitted a legislative proposal to subject flexible benefit plans to the hospital insurance tax, the proposal was not included in the President's FY 2001 budget.</p>	291
<p>Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)</p>	<p>The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's FY 2001 budget.</p>	210

OIG Recommendation	Status	Savings in Millions
<p>Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)</p>	<p>The HCFA did not concur with the recommendations. Although the BBA of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	\$157.3
<p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)</p>	<p>The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. The Congress decided (through the BBA of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules. The President's FY 2001 budget would reduce payments for four high-volume laboratory tests.</p>	130
<p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The HCFA should also begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participation, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94-00039; OEI-01-94-00230)</p>	<p>The HCFA concurred with OIG's recommendations. The President's FY 2001 budget proposes to allow an assessment of a \$1 fee on claims not submitted electronically.</p>	126
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>The FY 2001 budget proposes applying the consumer price index-urban adjustment to generic as well as brand name drugs. The OIG is continuing to monitor the Medicaid drug rebate program.</p>	123

OIG Recommendation	Status	Savings in Millions
<p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The HCFA agreed to recover the improper Medicare billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. Therefore, no legislative proposal was included in the President's current budget.</p>	\$83.5
<p>Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p>	<p>The HCFA considered a proposal recommending that the Medicare 190-day lifetime limit for psychiatric admissions be extended to general hospitals; however, such a proposal was not included as part of the President's FY 2001 budget.</p>	47.6
<p>Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)</p>	<p>The HCFA issued a final regulation which addresses the coverage of ambulance services and vehicle and staff requirements. The agency intends to address advanced and basic life support services as part of the negotiated rulemaking process on the ambulance fee schedule which began in early 1999.</p>	47
<p>Limit Reimbursement for Hospital Beds: The HCFA should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)</p>	<p>The HCFA concurred with the recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency has included hospital beds and supplies as part of its ongoing competitive bidding demonstration project for durable medical equipment.</p>	40

OIG Recommendation	Status	Savings in Millions
<p>Reduce End Stage Renal Disease Payment Rates:</p>	<p>The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but HCFA did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the BBA of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA began these audits in the fourth quarter of FY 1999.</p>	\$22*
<p>Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services:</p>	<p>The HCFA wrote to all State Medicaid directors on January 15, 1997, alerting them to the OIG review, encouraging them to use Medicare's bundling policies and urging them to install appropriate payment edits in their claim processing systems.</p>	17.8
<p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100; CIN: A-04-98-01185)</p>		

*This savings estimate represents program savings of \$22 million for each dollar reduction in the composite rate.

OIG Recommendation	Status	Savings in Millions
<p>Medicare Orthotics: Develop guidelines that better define orthotic devices; develop policies for orthotic codes; develop screens for billing many orthotic devices on the same day or within a short time frame; pay special attention to billing for orthotics in nursing facilities; work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together, and consider stricter standards to determine who is allowed to bill for orthotics. (OEI-02-95-00380)</p>	<p>The HCFA concurred with the recommendations and has revised its national codes to distinguish among categories of devices. The OIG is currently conducting a follow-up to this study.</p>	<p>\$10</p>
<p>Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p>	<p>The FY 2001 budget does not include this type of legislative proposal.</p>	<p>9.1</p>
<p>Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The HCFA agreed with the recommendation, and the BBA of 1997, as amended by the Balanced Budget Refinement Act of 1999, reduces the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p>	<p>to be determined</p>
<p>Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)</p>	<p>The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services and included this proposal in an earlier budget submission. Although the BBA of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	<p>to be determined</p>

OIG Recommendation	Status	Savings in Millions
<p>Home Health Agencies: The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (CIN: A-04-95-01103; CIN: A-04-95-01104; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170; CIN: A-04-94-02087; CIN: A-04-94-02078; CIN: A-04-96-02121; CIN: A-04-97-01169; CIN: A-04-97-01166; CIN: A-04-97-01170; CIN: A-04-99-01194)</p>	<p>Although the Congress and the Administration included provisions to restructure home health benefits in the BBA of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. The OIG will continue to do work in this area.</p>	to be determined
<p>Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The HCFA should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on AWP or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand name drugs with the highest total Medicaid reimbursements in Calendar Years 1994-96. (CIN: A-06-97-00052)</p>	<p>The HCFA disagreed with the recommendation to seek a legislative change, believing that such legislation was not feasible at the time. However, HCFA stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.</p>	to be determined
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
<p>Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)</p>	<p>In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2000 President's budget request for FDA proposes that FDA be given new user fee authority to enhance premarket review activities for medical devices and food additive petitions.</p>	\$75.9
<p>Medicare Rates for Indian Health Service Contracted Health Services: The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)</p>	<p>The IHS concurred with OIG's recommendations and is continuing its legislative, regulatory and administrative efforts to obtain discount rates throughout its service area. However, no legislative proposal is included in the FY 2001 budget.</p>	8.2

OIG Recommendation	Status	Savings in Millions
Recharge Center Costs:		
<p>The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p>	<p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.</p>	\$1.9
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Medical Child Support:		
<p>Increase the number of noncustodial parents providing medical support for their children and reduce Medicaid costs by either requiring noncustodial parents to pay for all or part of the Medicaid premiums or establishing a new comprehensive health insurance plan for children with premiums paid by noncustodial parents. (CIN: A-01-97-02506)</p>	<p>The Administration for Children and Families and HCFA agreed with OIG's findings and recommendations. State officials will move to consider a legislative change and budget option to address the recommendation.</p>	11.4
GENERAL OVERSIGHT		
Simplify Administrative/Indirect Cost Allocation Systems:		
<p>The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)</p>	<p>Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.</p>	660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

This schedule represents Office of Inspector General (OIG) findings and recommendations which, if implemented, would result in substantial benefits. The benefits relate primarily to effectiveness rather than cost-efficiency. More detailed information may be found in OIG's Program and Management Improvement Recommendations (the Orange Book).

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
Improve the Health Care Financing Administration's Implementation of the Federal Managers' Financial Integrity Act Program: <p>The Health Care Financing Administration (HCFA) should reevaluate its review of the Common Working File to ensure that all functional responsibilities of the system are included in Federal Managers' Financial Integrity Act reviews. (CIN: A-14-93-03026)</p>	The HCFA still does not agree with the need to expand financial management reviews to other systems, such as the Common Working File.
Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates: <p>The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)</p>	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA also has a task force to help with rebate resolution.
Ensure that the Medicare Accounts Receivable Balance Is Fairly Presented: <p>The HCFA should require contractors to implement or improve internal controls and systems to provide sufficient documentation to support reported accounts receivable. Because of insufficient documentation, OIG again was not able to satisfy itself as to the fair presentation of the Medicare accounts receivable balance (\$3.6 billion in FY 1998). (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098)</p>	The HCFA has contracted with a consulting service to assist in validating the FY 1998 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 1999, and to recommend any accounting changes or adjustments.
Consider Recommended Safeguards over Medicaid Managed Care Programs: <p>The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)</p>	The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.

OIG Recommendation	Status
<p>Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</p> <p>The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	<p>The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP, but did not provide specific written methodology for computing AMP.</p>
<p>Physician Office Surgery:</p> <p>The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p>	<p>The HCFA has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.</p>
<p>Properly Account for Medicare Secondary Payer Overpayments:</p> <p>Although agreement was reached to relieve Blue Cross and Blue Shield plans of past due Medicare secondary payer (MSP) overpayments, HCFA should continue to implement financial management systems to ensure that all overpayments (receivables) are accurately recorded. (CIN: A-09-89-00100)</p>	<p>The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans.</p>
<p>Investigate Patient Dumping Complaints:</p> <p>The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Workmen in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)</p>	<p>The HCFA concurred with OIG's recommendations.</p>
<p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services:</p> <p>The HCFA should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)</p>	<p>The HCFA concurred. The HCFA conducts annual evaluations to identify ways to improve performance. The HCFA is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.</p>
<p>Pressure Reducing Support Services:</p> <p>The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p>	<p>The HCFA did not concur.</p>
<p>Medicaid Accounts Receivable and Accounts Payable:</p> <p>The HCFA should continue its annual survey process or find a suitable alternative to estimate net accounts payable. Trend data on receivables and payables over time should be developed for each State and used to improve the estimation model. (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098)</p>	<p>The HCFA sent the FY 1998 survey to the States well in advance of the due date.</p>

OIG Recommendation**Status**

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Require Participation in the 340B Drug Pricing Program:

To ensure that grantees are accessing lower priced drugs, which enables them to provide additional services, the Health Resources and Services Administration (HRSA) should require all eligible entities to participate in the 340B drug pricing program. (CIN: A-01-98-01500)

The HRSA published a Federal Register notice that would require all eligible entities to participate in the 340B program. Because all responses to the notice were negative, HRSA instead decided to address the issue administratively by issuing a policy statement and guidance to grantees.

ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING

Improve the Federal Foster Care Program:

The OIG provided options for the Administration for Children and Families (ACF) to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)

The ACF concurred and is piloting redesigned titles IV-B and IV-E child welfare reviews. A notice of proposed rulemaking was published in September 1998, and the final rule is in clearance. In addition, the child welfare waiver demonstrations are allowing several States to test alternative approaches to the title IV-E requirements.

GENERAL OVERSIGHT

Update Cost Principles for Federally Sponsored Research Activities:

The Department should act to modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)

The Department is revising hospital cost principles to be consistent with OMB circulars.

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted downward by \$46.9 million.

² During the period, revisions to previously reported management decisions included:

CIN: A-04-99-55653	State of Tennessee: The Federal share of funds to be returned to the program was revised by \$451,000.
CIN: A-06-97-45889	Eight Northern Indian Pueblos Council: The grantee supplied supporting documentation for \$61,295.

Not detailed are revisions to previously disallowed management decisions totaling \$117,880.

³ Included are management decisions to disallow \$328,593 in audits performed by the Defense Contract Audit Agency.

⁴ Included are management decisions to disallow \$33.6 million that was identified in nonfederal audit reports.

⁵ Audits on which a management decision had not been made within 6 months of issuance of the report:

A. Due to administrative delays, many of which are beyond managements control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-05-94-00064	MI Blue Cross/Blue Shield, Audit of Admin. Costs, June 1996, \$15,609,718
CIN: A-07-96-01176	Medicare Excess Pension Assets - BC Mich., Nov. 1996, \$11,904,263
CIN: A-03-97-00013	BCBSM FY 89-92 Incremental Claim, Sept. 1998, \$11,723,785
CIN: A-07-98-02522	Pension Segmentation Blue Shield of California Termination, April 1999, \$7,623,524
CIN: A-09-97-44262	State of California, April 1997, \$7,419,900
CIN: A-03-91-00052	Independent Living Program - National, March 1993, \$6,529,545
CIN: A-07-92-00578	BC/BS of Texas Inc. - Unfunded Pension Costs, Oct. 1992, \$6,244,637
CIN: A-07-97-01213	Pension - Travelers Termination, Feb. 1998, \$5,624,747
CIN: A-05-96-00058	Close-Out Audit of Medicare Contract - BCBS - MI, Dec. 1997, \$5,226,443
CIN: A-09-99-57988	State of Arizona, June 1999, \$4,950,000
CIN: A-01-97-00516	Admin. Costs Parts A&B, Railroad Retirement Board, June 1999, \$4,939,184
CIN: A-07-96-02001	Medicare Part B Admin. Costs at BC/BS Colorado, Dec. 1996, \$4,483,104
CIN: A-07-98-01224	BC/BS KY Unfunded Pension Costs, Oct. 1998, \$4,286,294
CIN: A-07-97-01234	Rocky Mountain Pension - Termination, May 1998, \$4,079,171
CIN: A-05-94-00080	Associated Ins. Medicare Administrative Costs, July 1996, \$3,954,632

CIN: A-09-95-00056 Review of Training Activities - CA Dept. of Social Services, Aug. 1996, \$3,934,717

CIN: 06-97-00029 Retention of Fees Child Placing Agencies Louisiana, Sept. 1998, \$3,450,173

CIN: A-02-95-01019 Staff Builders Home Office Medicare Cost Rev. ORT, Aug. 1998, \$3,434,274

CIN: A-05-93-00054 II. Associated Insurance Group Contract Audit, Oct. 1993, \$3,355,560

CIN: A-03-94-00029 Veritus Inc. - Admin Cost, Feb. 1998, \$3,140,363

CIN: A-04-98-01188 Review Administrative Costs at Medicare Managed Risk Plan, August 1999, \$3,032,637

CIN: A-07-93-00633 Pension Segmentation Aetna Life Insurance Co., October 1993, \$3,011,376

CIN: A-05-93-00013 MI - Blue Cross/Blue Shield - Contract Medicare Audit, April 1993, \$3,010,916

CIN: A-09-98-50183 State of California, Mar. 1998, \$3,000,000

CIN: A-07-92-00585 Pension Segmentation BC/BS of California, Jan. 1994, \$2,973,503

CIN: A-01-95-00504 Medicare Parts A&B Admin Costs - AETNA, Jan. 1996, \$2,938,223

CIN: A-01-96-00508 Medicare - Admin. Costs Parts A&B and RRB - Travelers, Mar. 1996, \$2,803,260

CIN: A-07-96-01185 BCBS Rocky Mountain Pension Segmentation, June 1997, \$2,743,438

CIN: A-05-97-00005 Administrative Costs Claimed under Medicare A & B, Feb. 1998, \$2,569,067

CIN: A-07-92-00579 BC/BS of Michigan Inc. - Unfunded Pension Costs, Oct. 1992, \$2,535,698

CIN: A-05-92-00026 Associated Insurance Co. - Medicare Admin., Feb. 1992, \$2,530,409

CIN: A-07-98-02523 Blue Cross of California, FACP, April 1999, \$2,408,019

CIN: A-02-91-01006 Blue Shield of Western NY Medicare Adm. CTS. Porter, Sept. 1991, \$2,379,239.

CIN: A-04-97-01166 Rev. of Home Health Services by Staff Builders Home Health, April 1999, \$2,300,000

CIN: A-04-97-01170 Rev. of Home Health Services by Medicare Home Health Services, April 1999, \$2,200,000

CIN: A-02-93-02001 Manpower Demonstration Res. Corp., Oct. 1994, \$2,024,444

CIN: A-04-97-01169 Review of Home Health Services by Medtech Homes Health Services, April 1999, \$1,900,000

CIN: A-06-96-00009 New Mexico BCBS Admin Cost - Contracted, Nov. 1997, \$1,879,366

CIN: A-05-97-00014 Group Health Plan Inc. (Healthpartners) Inst. Benes, June 1998, \$1,808,308

CIN: A-05-95-00059 Audit of Administrative Costs - BCBS Michigan, Jan. 1997, \$1,787,345

CIN: A-15-98-00038 Contract Closeout Audit for CTS, Inc., July 1999, \$1,590,692

CIN: A-03-96-00012 BCBSM PT-B Non-Renewal Costs, Aug. 1998, \$1,557,459

CIN: A-06-96-00008 Arkansas BCBS Admin. Cost - Contracted, Sept. 1996, \$1,442,193

CIN: A-02-96-42454 City of New York HRA Agency for Child Development, May 1996, \$1,410,441

CIN: A-05-93-00057 Michigan Blue Cross and Blue Shield of Michigan Contract Audit, July 1993, \$1,409,954

CIN: A-07-98-02506 AETNA Unfunded Pension Costs, Aug. 1998, \$1,407,689

CIN: A-09-96-00064 ORT - Hospice - California, Mar. 1997, \$1,350,000

CIN: A-10-91-00011 WPS - Keystone Computer Acquisition, Oct. 1992, \$1,346,681

CIN: A-05-95-00042 BCBSA Administrative Costs - Contracted Audit, Dec. 1995, \$1,333,598

CIN: A-02-96-01016 Empire Admin. Costs Part A - Gardiner, Kamy & Assoc., April 1997, \$1,296,098

CIN: A-07-93-00700 BC/BS of Mass - Unfunded Pension Cost Audit, May 1994, \$1,290,740

CIN: A-07-96-01194 Pension - Community Mutual Segmentation, July 1997, \$1,263,188

CIN: A-07-97-01223 Pensions - Kentucky Blues/Segmentation, Oct. 1998, \$1,236,890

CIN: A-07-94-00762 Health Care Service Corp. - Unfunded Pension Costs, July 1994, \$1,233,337

CIN: A-07-93-00665 Travelers Insurance Co. - Unfunded Pension Cost AUD, Oct. 1993, \$1,218,963

CIN: A-05-98-00050 Follow-up Medicaid Clinical Laboratories, July 1999, \$1,097,036

CIN: A-02-94-01029 Hospice Eligibility RVW IN PR - SAN German - ORT, June 1995, \$1,070,814

CIN: A-09-98-00052 California Medical Review Inc., Jan. 1999, \$1,067,991

CIN: A-07-94-00763 Health Care Serv. Corp. - Pension Segmentation, Aug. 1994, \$1,055,458

CIN: A-05-94-00047 Nationwide Ins., Medicare Part B Admin. Costs, Sept. 1995, \$1,049,309

CIN: A-07-93-00634 Pension Segmentation - Travelers Insurance Co, Oct. 1993, \$1,026,460

CIN: A-01-98-00500 Payment Edits for Psychiatric at MA Part B Carrier, Sept. 1998, \$1,000,000

CIN: A-07-97-01208 Pension - Community Mutual FACP, July 1997, \$991,972

CIN: A-06-95-00035 Fees Retained by Child Placing Agencies, Feb. 1996, \$988,680

CIN: A-09-94-01010 Closeout Audit " Cont. No. N01-ES-75196 (Stratagene), Mar. 1994, \$983,208

CIN: A-08-99-55285 NA - South Dakota Urban Indian Health Inc., June 1999, \$902,377

CIN: A-08-99-55284 NA - South Dakota Urban Indian Health Inc., June 1999, \$902,046

CIN: A-05-92-00060 Contractor Audit of BCBS, Feb. 1993, \$879,609

CIN: A-02-94-01022 Blue Cross Blue Shield NJ - Admin. Cost Medicare, Sept. 1997, \$864,851

CIN: A-07-98-02533 Travelers FACP, Dec. 1998, \$854,214

CIN: A-07-93-00701 BC/BS of Mass - Pension Cost - Charge Audit, July 1994, \$839,740

CIN: A-06-99-00008 Oklahoma Foster Care Program Maintenance Payments, Mar. 1999, \$737,239

CIN: A-07-98-01225 BC/BS KY Pension Costs Claimed, Oct. 1998, \$736,134

CIN: A-05-91-00136 Community Mutual Ins. Co. Admin. Costs, Aug. 1992, \$720,668

CIN: A-07-96-01195 Pension - New Mexico Segmentation, Feb. 1997, \$700,952

CIN: A-09-97-00078 Physician Billings - Dr. Spencer, Jan. 1999, \$683,264

CIN: A-04-99-54416 State of Florida, Nov. 1998, \$668,791

CIN: A-07-93-00699 BC/BS of Mass - Pension Segmentation Audit, April 1994, \$658,471

CIN: A-02-96-01015 Empire Admin. Costs Part A - Gardiner, Kamy & Assoc., April 1997, \$652,492

CIN: A-01-98-00503 Psychiatric Outpt. Services at The Franklin Med. Ctr., Nov. 1998, \$646,517

CIN: A-07-97-02503 Pension Kansas City BC/BS Termination, July 1998, \$635,984

CIN: A-07-96-01178 Medicare Pension Costs Claimed BC Mich., Nov. 1996, \$631,248

CIN: A-04-94-01078 Monitoring Admin. Cost - Audit Medicare Pt. B BCBSSC, July 1994, \$594,092

CIN: A-10-99-57240 State of Idaho, Jan. 1999, \$594,000

CIN: A-04-93-01069 Monitoring Admin. Cost Audit Medicare Part A BCBSSC, July 1994, \$590,844

CIN: A-07-93-00679 AETNA - Unfunded Pension Cost Audit, May 1994, \$590,207

CIN: A-02-97-47130 Middlesex County Economic Opportunities Corp., June 1997, \$578,550

CIN: A-07-97-01207 Pension - Community Mutual Unfunded Pension, July 1997, \$571,413

CIN: A-03-97-00009 Peer Review Systems INC/CCAS/Ohio, Mar. 1997, \$545,405

CIN: A-07-96-01198 Pension - Rocky Mountain Unfunded, Feb. 1997, \$543,421

CIN: A-02-91-03508 Audit of NJ Child Care and Supportive Services, June 1993, \$506,710

CIN: A-09-99-56858 Hawaii Dept. of Human Services, Feb. 1999, \$502,000

CIN: A-03-92-16229 State of Pennsylvania, March 1992, \$496,896

CIN: A-07-96-01188 Pro Closeout - DOSHI CPA, Aug. 1996, \$432,698

CIN: A-07-97-01235 DOSHI - Texas, June 1997, \$424,255

CIN: A-06-99-56489 State of Louisiana, Jan. 1999, \$421,206

CIN: A-09-98-49239 NA - Hermandad, Mexicana National Legal Center Inc., Nov. 1997, \$419,364

CIN: A-05-97-00013 Pacificare of CA - HMO Institutional Status Project, April 1998, \$407,784

CIN: A-06-99-58928 Arkansas Office of Child Support Enforcement, April 1999, \$367,273

CIN: A-01-99-57863 State of Connecticut, May 1999, \$361,315

CIN: A-04-96-01134 Partic. Part of HCFA Surv. Team - Colonnade MCAL - ORT, Feb. 1997, \$358,338

CIN: A-04-96-01136 Partic. Part of HCFA Surv. Team - Survey Savannah -ORT, Dec. 1996, \$354,537

CIN: A-05-92-00126 Wisconsin Westcap Head Start, March 1993, \$347,576

CIN: A-08-99-59907 NA - Crow Creek Sioux Tribe, July 1999, \$344,504

CIN: A-05-93-25697 West Central Wisconsin Community Action Agency, Inc., Aug. 1993, \$324,759

CIN: A-04-97-01175 Keystone Pro, June 1998, \$310,787

CIN: A-07-98-02501 CT. BC/BS Unfunded Pension Costs, Mar. 1998, \$292,152

CIN: A-08-99-59826 NA - Crow Creek Sioux Tribe, July 1999, \$291,718

CIN: A-04-96-01129 Parti. Part HCFA Surv. Team - Ameri. Trans. Care (ORT), Feb. 1997, \$284,378

CIN: A-05-96-00069 CPA Audit of Hooper Holmes HHA G&A - OT Case Open, Feb. 1998, \$280,515

CIN: A-09-04-30178 State of Arizona, June 1994, \$267,021

CIN: A-09-99-57442 Morongo Band of Mission Indians, July 1999, \$265,002

CIN: A-05-98-53935 Montgomery County Community Action Agency Inc., June 1998, \$257,702

CIN: A-04-99-54767 Anderson - Oconee Head Start Project Inc., Oct. 1998, \$254,673

CIN: A-07-93-00710 BC/BS of Connecticut - Unfunded Pension Cost Audit, Mar. 1994, \$237,392

CIN: A-04-97-01152 Closeout Audit - Michigan Pro, June 1997, \$228,630

CIN: A-04-96-01135 Partic. Part of HCFA Surv. Wash. Manor Nursing - ORT, Feb 1997, \$220,483

CIN: A-09-96-00094 ORT - Monitor CPA Audit of Dynasty HHA Cost Report, July 1997, \$217,720

CIN: A-06-99-56489 State of Louisiana, Jan. 1999, \$213,709

CIN: A-09-05-34788 State of Arizona, Aug. 1995, \$209,462

CIN: A-05-96-00052 ORT Assist - Ancillary Costs - NW Com. Hosp., June 1997, \$206,508

CIN: A-03-98-00014 Connecticut Pro Inc/CCAS/HHS-100-95-0033, Feb. 1998, \$202,662

CIN: A-06-96-00064 ORT SNF Research at Methodist Hospital, Jan 1997, \$200,000

CIN: A-01-97-00531 Medicare Administrative Costs - MABCBS, June 1998, \$198,950

CIN: A-05-97-00006 MI - Wayne State U/NIH Request/Romero Grant, June 1997, \$195,809

CIN: A-10-96-00007 Idaho Migrant Council Head Start, March 1997, \$192,981

CIN: A-04-98-01181 Massachusetts Peer Review Organization (MPRO), June 1998, \$183,074

CIN: A-03-99-00007 Forest Ambulance Service - External, Dec. 1998, \$173,189

CIN: A-05-94-29229 West Central Wisconsin Community Action Agency, March 1994, \$167,977

CIN: A-05-96-00031 WIPRO/Equipment Depreciation, Aug. 1996, \$167,033

CIN: A-04-98-49312 NA - State of North Carolina, Nov. 1997, \$164,792

CIN: A-03-97-00016 Quality Improvement Pro INC/CCAS/Puerto Rico, Feb. 1998, \$158,925

CIN: A-03-98-00034 Freestate HP/Institutional Status/Medicare, March 1999, \$156,987

CIN: A-07-98-02526 Unfunded Pension Liability - BCBS of Arkansas, Sept. 1998, \$153,269

CIN: A-07-99-01039 Task Order Review of Human Dev. Corp. SLMO, Aug. 1999, \$146,999

CIN: A-08-99-60402 State of South Dakota, July 1999, \$142,748

CIN: A-07-99-54163 Ponca Tribe of Nebraska, May 1999, \$141,475

CIN: A-04-96-01147 ORT Rev. Parker Jewish Geriatric Ctr., New Hyde, NY, April 1997, \$140,188

CIN: A-03-98-00025 Abingdon Ambulance Company, Abingdon, VA, Jan. 1999, \$139,325

CIN: A-06-99-58786 Arkansas Dept. of Human Services, Mar. 1999, \$137,218

CIN: A-09-99-52846 Inter-Tribal Council of California Inc., Feb. 1999, \$136,360

CIN: A-02-98-01002 IPRO Closeout Audit - CPA Contract Monitoring, Dec. 1998, \$135,492

CIN: A-02-99-59294 City of New York, New York, Aug. 1999, \$134,835

CIN: A-07-97-02500 Pension Segmentation BC/BS Connecticut, Mar. 1998, \$122,548

CIN: A-07-93-00709 BC/BS of Connecticut - Pension Segmentation Audit, April 1994, \$119,472

CIN: A-05-97-00023 Kaiser Foundation - HMO Institutional Status Project, April 1998, \$116,096

CIN: A-03-99-00003 AETNA Healthcare , July 1999, \$113,993

CIN: A-03-95-03329 Henderson Associates/CACS/ASC/282-91-0012, Mar. 1997, \$111,289

CIN: A-02-96-01001 WNS of NY Home Care - ORT/HHA Target, Sept. 1997, \$110,841

CIN: A-02-96-02001 International Rescue Committee - Refugee Program, Jan 1998, \$108,604

CIN: A-06-99-56908 Pueblo of ACOMA, July 1999, \$104,186

CIN: A-09-99-59788 Palau, Community Action Agency, June 1999, \$102,653

CIN: A-03-98-03300 Raymond Maria Group - Contract Closeout, March 1998, \$102,476

CIN: A-09-00-59834 Government of Guam, June 1999, \$99,978

CIN: A-07-95-01159 ME BCBS Pension Segmentation, Jan. 1996, \$96,955

CIN: A-09-97-00066 Walter McDonald - Indirect Cost Rate Audit, Mar. 1998, \$95,733

CIN: A-03-98-00007 Delmarva Pro/CCAS/Maryland, DC/HHS-100-95-0029, Dec. 1998, \$95,709

CIN: A-09-98-00065 CSBG Disc. Grant #90EE004901 - Latino Resources, Jan. 1999, \$95,102

CIN: A-10-97-00003 BCWAAK-ADM Costs Remote Network Activities FY 93 & 94, Feb. 1998, \$94,643

CIN: A-01-99-60258 State of Connecticut, July 1999, \$94,029

CIN: A-06-96-43195 Pueblo of Isleta, June 1996, \$92,969

CIN: A-07-95-01164 Medicare Admin. Costs - General American, Dec. 1995, \$89,929

CIN: A-01-99-57358 Organix Inc., Feb. 1999, \$89,395

CIN: A-08-99-56914 Rural America Initiatives, July 1999, \$87,468

CIN: A-02-95-34277 Puerto Rico Dept. of Health, June 1995, \$86,064

CIN: A-02-95-34278 Puerto Rico Dept. of Health, June 1995, \$85,266

CIN: A-04-96-38655 State of North Carolina, April 1996, \$83,237

CIN: A-09-99-56382 Metropolitan Area Advisory Committee, Jan. 1999, \$82,600

CIN: A-01-96-00505 CFO Audit of HCFAs Financial Statements, July 1997, \$80,236

CIN: A-03-98-00008 VA Health Quality Center Review ORG/Pro/CCAS/VA, Dec 1998, \$78,207

CIN: A-04-96-01137 Partic. Part of HCFA Surv. Team - Daytona Nursing - ORT, Dec. 1996, \$76,130

CIN: A-02-97-47130 Jackson-Vinton Community Action Inc., July 1997, \$75,392

CIN: A-02-99-58263 Puerto Rico Office of The Governor Office of Child, July 1999, \$73,819

CIN: A-07-95-01166 Unfunded Pension Costs Nebraska BC/BS, Jan. 1996, \$73,509

CIN: A-01-97-00520 CFO Audit of HCFAs Financial Statements, July 1998, \$69,031

CIN: A-02-95-34275 Puerto Rico Dept. of Health, June 1995, \$64,841

CIN: A-06-99-56886 NA - Cheyenne - Arapaho Tribes of Oklahoma, July 1999, \$64,635

CIN: A-10-99-57105 Nez Perce Tribe, April 1999, \$63,066

CIN: A-06-99-59854 State of Louisiana, August 1999, \$61,288

CIN: A-05-96-00072 MI Dept. Of Community Health/Medicaid Lab Services, August 1997, \$59,956

CIN: A-05-96-00051 ORT Assist-Ancillary Costs - St. Joseph, June 1997, \$58,008

CIN: A-09-97-00059 Health Services Advisory Group, Inc. PRO-AZ, May 1997, \$57,925

CIN: A-08-99-54138 Rosebud Sioux Tribe, Nov. 1998, \$56,223

CIN: A-04-96-01125 Partic. - Part of HCFA Survey Team - Rosemont - ORT, Feb. 1997, \$55,306

CIN: A-05-98-51855 Stark County Community Action Agency, Mar. 1998, \$54,933

CIN: A-07-99-59813 State of Iowa, Aug. 1999, \$54,662

CIN: A-07-97-01206 Pension - Washington/Alaska-Unfunded, Mar. 1997, \$54,000

CIN: A-07-98-50741 Citizen Housing Information Council Inc., Mar. 1998, \$52,758

CIN: A-05-98-51302 Kootasca Community Action Inc., Feb. 1998, \$52,000

CIN: A-09-95-00095 Health Services Advisory Group, Inc., (HSAG), Dec. 1995, \$49,585

CIN: A-03-93-03306 Survey Research Assoc. CACS N01-ES-45067, Dec. 1993, \$48,779

CIN: A-02-95-34276 Puerto Rico Dept. of Health, June 1995, \$46,842

CIN: A-10-99-58040 State of Washington, Aug. 1999, \$44,350

CIN: A-09-99-56858 Hawaii Dept. of Human Services, Feb. 1999, \$44,144

CIN: A-09-99-52845 Inter-Tribal Council of California Inc., Feb. 1999, \$43,315

CIN: A-09-99-59787 Palau Community Action Agency, June 1999, \$40,212

CIN: A-03-97-44742 Association of Teachers of Preventive Medicine Inc., Feb. 1998, \$37,260

CIN: A-07-98-53295 Winnebago Tribe of Nebraska, Sept. 1998, \$36,808

CIN: A-03-99-57965 NA - District of Columbia Dept. of Human Services, Feb. 1999, \$35,975

CIN: A-05-99-59494 Sheboygan Human Rights Association Inc., May 1999, \$35,786

CIN: A-07-98-02030 DOSHI - CPA Report, Nov. 1997, \$35,703

CIN: A-07-97-01218 DOSHI - Utah/Nevada FMC, Mar. 1997, \$33,752

CIN: A-03-99-56842 National Association for Equal Opportunity in High, Feb. 1999, \$33,585

CIN: A-01-99-57863 State of Connecticut, May 1999, \$33,346

CIN: A-06-97-47794 Gulf Coast Community Action Inc., May 1997, \$32,619

CIN: A-07-97-01199 BCBS New Mexico Unfunded Pension Cost, Feb. 1997, \$31,372

CIN: A-09-96-42547 Maricopa County Arizona, April 1996, \$30,766

CIN: A-09-98-49616 State of Arizona, Nov. 1997, \$29,746

CIN: A-05-97-48015 Hoosier Valley Economic Corp., May 1997, \$29,004

CIN: A-03-98-03301 AAUAP - Incurred Cost Review - HHS 105-95-7011, April 1998, \$28,289

CIN: A-02-99-58263 Puerto Rico Office of The Governor Office of Child, July 1999, \$27,980

CIN: A-10-98-00008 Review of EVRGRN Comm. Dev. Corp. OCSBG #90EE001301, Dec. 1998, \$27,316

CIN: A-10-96-41391 Klamath Family Head Start, April 1996, \$26,530

CIN: A-03-92-00033 Blue Cross of West Virginia Termination, Nov. 1992, \$25,200

CIN: A-04-99-54416 State of Florida, Nov. 1998, \$24,165

CIN: A-09-04-27868 Inyo Mono Advocates for Community Action, Nov. 1993, \$22,875

CIN: A-10-97-43797 State of Washington, Jan. 1997, \$21,241

CIN: A-05-96-39685 Michigan Family Resources, Dec. 1995, \$20,799

CIN: A-05-96-43041 Hoosier Valley Economic Opportunity Corp., June 1996, \$20,438

CIN: A-01-99-59104 Planned Parenthood of Connecticut Inc. & Subsidiar., Aug. 1999, \$18,791

CIN: A-04-97-01163 VIMI Medicare Pro Contract Audit, Sept. 1997, \$18,758

CIN: A-05-93-21928 Wright State Univ. July 1993, \$18,308

CIN: A-05-99-58280 Rock Island School District No. 41, Aug. 1999, \$17,742

CIN: A-03-97-00007 NE Health Care Quality Foundation/CCAS/N Hampshire, Mar. 1997, \$17,045

CIN: A-01-99-55594 State of Vermont, Nov. 1998, \$16,623

CIN: A-01-97-44143 Brandeis Univ., Jan. 1997, \$16,602

CIN: A-05-95-34584 Wood County Head Start Inc., Dec. 1994, \$14,896

CIN: A-03-97-00008 NE Health Care Quality Foundation/CCAS/N. Hampshire, Mar. 1997, \$14,596

CIN: A-07-99-60332 State of Nebraska, July 1999, \$14,209

CIN: A-06-98-54189 City of Houston, Texas, July 1998, \$14,146

CIN: A-09-96-00050 CFO - HCFA 1996, Nov. 1997, \$13,924

CIN: A-07-95-01175 Mutual of OMAHA - Admin. Costs, August 1996, \$13,564

CIN: A-07-99-57985 State of Kansas, Feb. 1999, \$13,550

CIN: A-05-95-36498 Hoosier Valley Economic Opportunity Corp., April 1995, \$13,116

CIN: A-03-98-50338 National Medical Association, Feb. 1998, \$12,968

CIN: A-06-99-56886 NA - Cheyenne-Arapaho Tribes of Oklahoma, July 1999, \$11,768

CIN: A-04-99-59501 Chape Hill - Carroro City Board of Education, June 1999, \$11,256

CIN: A-10-97-00002 Group Health Institutionalized, Nov. 1997, \$9,769

CIN: A-10-97-48639 NA - Nooksack Indian Tribe, Aug. 1997, \$9,440

CIN: A-04-97-01153 MS Found. - MCAL Care, Medicare Pro Contract Audit, Sept. 1997, \$9,070

CIN: A-08-99-56446 Sisseton-Wahpeton Sioux Tribe, May 1999, \$9,000

CIN: A-04-98-49581 Mid-South Foundation for Medical Care Inc., Jan. 1998, \$8,938

CIN: A-02-95-34277 Puerto Rico Dept. of Health, June 1995, \$8,486

CIN: A-05-99-59468 Community Care in Union County Inc., July 1999, \$8,464

CIN: A-10-98-53162 People of Color Against AIDS Network, April 1998, \$8,289

CIN: A-07-97-01231 Prowest - DOSHI Washington, June 1997, \$8,027

CIN: A-05-97-48015 State of Connecticut, May 1999, \$7,686

CIN: A-03-91-02004 W VA Termination Cost Audit, Nov. 1992, \$7,556

CIN: A-03-96-38803 Skyline Government Services Corp., Nov. 1995, \$7,285

CIN: A-03-98-00045 Temple Univ/Physician Credit Balances Medicare, July 1999, \$7,280

CIN: A-07-97-01227 MT-WY Foundation for Medical Care, June 1997, \$7,168

CIN: A-03-99-58532 Advocates for Youth, May 1999, \$7,138

CIN: A-01-97-49174 Brandeis Univ., Aug. 1997, \$7,068

CIN: A-06-96-40858 CADDO Community Action Agency Inc., Feb. 1996, \$6,557

CIN: A-05-99-60704 Head Start Operation for Preschool Education, Aug. 1999, \$6,275

CIN: A-04-99-56945 Ouitman County Development Organization Inc., Mar. 1999, \$6,142

CIN: A-07-95-01167 Pension Costs Claimed Nebraska BC/BS, Jan. 1996, \$6,075

CIN: A-02-96-02001 International Rescue Committee - Refugee Program, Jan. 1998, \$6,027

CIN: A-06-97-48062 Jobs for Progress National, July 1997, \$5,924

CIN: A-08-99-56446 Sisseton-Wahpeton Sioux Tribe, May 1999, \$5,843

CIN: A-10-98-50308 Coastal Community Action Program, Dec. 1977, \$5,274

CIN: A-05-98-51316 Community Action Program Inc. of Western Indiana, Feb. 1998, \$5,202

CIN: A-02-99-56463 Virgin Islands Advocacy Agency Inc., Nov. 1998, \$5,089

CIN: A-06-91-00034 Audit of Collection and Credit Activities at TDHS, Jan. 1992, \$5,081

CIN: A-09-97-48829 Community Action Commission of Santa Barbara Count., Aug. 1997, \$4,809

CIN: A-09-97-44435 Commonwealth of the Northern Mariana Islands, Oct. 1996, \$4,767

CIN: A-07-95-01123 Review of CPA Adm. Cost - BCBS of Kansas City, May 1995, \$4,045

CIN: A-04-97-01162 HMSA Medicare Pro Contract Audit, Sept. 1997, \$3,871

CIN: A-09-95-39056 Hawaii Dept. of Health, Sept. 1995, \$3,601

CIN: A-01-98-00512 CFO of HCFA's FY 1997 Medicare Benefit Payments, June 1998, \$3,264

CIN: A-03-95-03318 Trans Management Systems, May 1996, \$3,016

CIN: A-05-99-56827 Fond Du Lac Reservation, Mar. 1999, \$2,926

CIN: A-07-98-02502 CT. BC/BS Pension Costs Claimed, Mar. 1998, \$2,725

CIN: A-03-98-51505 Allied Signal Technical Services Corp., April 1998, \$2,722

CIN: A-03-95-34716 West Virginia Medical Institute Inc., Mar. 1995 \$2,688

CIN: A-02-97-49366 Seneca Nation of Indians, Sept. 1997, \$2,655

CIN: A-05-95-35315 Lake County Economic Opportunity Corp., Jan. 1995, \$2,650

CIN: A-01-97-45487 ABT Associates Inc., Jan. 1997, \$2,596

CIN: A-03-97-43996 Actuarial Research Corp., Oct. 1996, \$2,561

CIN: A-07-97-01221 Pro Closeout - DOSHI CPA - ARK FDN for Med. Care, Mar. 1997, \$2,096

CIN: A-09-98-53899 Stanford Univ., June 1998, \$2,058

CIN: A-03-96-44076 St. Pauls College, Aug. 1996, \$2,029

CIN: A-07-97-01232 Prowest - DOSHI ALASKA, June 1997, \$1,473

CIN: A-05-99-60620 Red Cliff Band of Lake Superior Chippewa Indians, July 1999, \$1,459

CIN: A-09-94-01022 Intelligenetics #N01-GM-72110, Oct. 1994, (\$12,400)

B. The following audit is in litigation:

CIN: A-10-98-51043 Nooksack Indian Tribe, May 1998, \$433,539

Table II

¹ The opening balance was adjusted to reflect an upward revaluation of \$214.4 million.

² Included in the total recommendations agreed to by management is \$724,893 resulting from Defense Contact Audit Agency recommendations.

³ Management decision has not been made within 6 months of issuance on 21 reports:

A. Discussions with management are ongoing and it is expected that the following audits will be resolved by the next semiannual reporting period:

CIN: A-04-97-00109 Emergency Assistance Claims - NC, July 1998, \$13,000,000

CIN: A-03-91-00552 Independent Living Program " National, Mar. 1993, \$10,161,742

CIN: A-15-97-50001 Audit of IHS Contract Health Services Program, Jan. 1999, \$8,000,000

CIN: A-01-97-02506 Review of the Avail. of Medical Coverage/CSE Support, June 1998, \$5,704,585

CIN: A-04-98-01188 Review Admin. Costs at Medicare Managed Risk Plan, Aug. 1999, \$2,559,357

CIN: A-09-95-00095 Health Services Advisory Group, Inc. (HSAG), Dec. 1995, \$1,389,723

CIN: A-07-97-01230 OFMQ - Doshi Oklahoma, June 1997, \$203,510

CIN: A-07-97-01231 Prowest - Doshi Washington, June 1997, \$163,552

CIN: A-05-96-43154 Muskegon-Oceana Community Action against Poverty I., June 1996, \$130,993

CIN: A-02-96-02001 International Rescue Committee - Refugee Program, Jan. 1998, \$90,528

CIN: A-01-98-02503 Survey of Garnishment of Income Other than Wages, May 1999, \$68,500

CIN: A-07-97-01235 Doshi - Texas, June 1997, \$51,334

CIN: A-07-97-01232 Prowest - Doshi Alaska, June 1997, \$21,218
CIN: A-05-96-00069 CPA Audit of Hooper Holmes HHA G&A - OI Case Open, Feb. 1998, \$17,555
CIN: A-07-95-01164 Medicare Admin. Costs - General American, Dec. 1995, \$16,632
CIN: A-07-97-01227 MT-WY Foundation for Medical Care, June 1997, \$13,461
CIN: A-06-97-45023 CADDO Community Action Agency Inc., Nov. 1996, \$8,880
CIN: A-01-97-00526 Psychiatric Outpatient Services, Mar. 1998, \$7,245
CIN: A-07-96-01188 Pro Closeout - Doshi CPA, Aug. 1996, \$5,667
CIN: A-05-95-37812 Northeast Michigan Community Service Agency Inc., Aug. 1995, \$2,191
CIN: A-01-98-00506 Psychiatric Outpatient at Newton-Wellesley Hospital, Mar. 1998, \$1,120

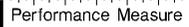
APPENDIX E

Reporting Requirements of the Inspector General Act of 1978, as Amended

The specific reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each of them is addressed. Where there is no data to report under a particular requirement, this is indicated as "none." A complete listing of Office of Inspector General audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	71
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	73
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	69
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	70
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

Performance Measures

In order to identify work done in the area of performance measurement, the Office of Inspector General (OIG) has labeled some items throughout the semiannual report as performance measures with the symbol . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG’s opinion, the following audits, inspections and investigations finalized during this semiannual period offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

	Page
Improper Fiscal Year 1999 Medicare Fee-for-Service Payments	2
Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1999	3
External Review of Hospital Quality: State Initiatives	4
Medicare Managed Care: Goals of National Marketing Guide	8
Medicare Managed Care: 1998 Marketing Materials	8
Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators’ Perspective	9
Medicare Beneficiary Access to Home Health Agencies	15
Medicare Home Health Services in California, Illinois, New York and Texas: A Follow-Up Review	16
Year 2000 Readiness	21
Safeguarding Medicare Accounts Receivable	23
Durable Medical Equipment Regional Carriers: Meeting HCFA’s Objectives	39
Food and Drug Administration’s Handling of Adverse Drug Reaction Reports	50
Comprehensive Hemophilia Treatment Centers’ Utilization of Public Health Service 340B Drug Pricing Program	51
National Institutes of Health Small Business Innovation Research Program	52
24-Month Performance Data for Administration on Aging’s Health Care Fraud Control Grants	63
Financial Statement Audit of the Department for Fiscal Year 1999	66

ACRONYMS

AARP	American Association of Retired Persons
ACF	Administration for Children and Families
ACR	adjusted community rate
ADR	adverse drug reaction
AHRQ	Agency for Healthcare Research and Quality
ALJ	administrative law judge
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	average wholesale price
BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMP	civil monetary penalty
CSE	child support enforcement
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
ESRD	end stage renal disease
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFP	Federal financial participation
FI	fiscal intermediary
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IDPN	intradialytic parenteral nutrition
IHS	Indian Health Service
IME	indirect medical education
MCO	managed care organization
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
OCSE	Office of Child Support Enforcement
OMB	Office of Management and Budget
OPDIV	operating division
PATH	physicians at teaching hospitals
PHS	Public Health Service
PIN	provider identification number
PPS	prospective payment system
PRO	peer review organization
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
UPIN	unique physician identification number
UPN	universal product number

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to the Congress. A selection of other statutory and administrative reporting and enforcement responsibilities and authorities are listed below:

AUDIT AND MANAGEMENT REVIEW RESPONSIBILITIES AND OFFICE OF MANAGEMENT AND BUDGET CIRCULARS

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
P.L. 103-62	Government Performance and Results Act of 1993
P.L. 103-355	Federal Acquisition Streamlining Act of 1994
P.L. 103-356	Government Management Reform Act of 1994
P.L. 104-156	Single Audit Act Amendments of 1996
P.L. 104-191	Health Insurance Portability and Accountability Act of 1996
P.L. 104-193	Personal Responsibility and Work Opportunity Act of 1996
P.L. 104-208	Federal Financial Management Improvement Act of 1996

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State, Local and Indian Tribal Governments
A-102	Grants and Cooperative Agreements with State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122	Cost Principles for Nonprofit Organizations
A-123	Management Accountability and Control
A-127	Financial Management Systems
A-129	Policies for Federal Credit Programs and Non-Tax Receivables
A-133	Audits of States, Local Governments and Non-Profit Organizations
A-134	Financial Accounting Principles and Standards

General Accounting Office Government Auditing Standards

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

- Title 5, United States Code, section 552a(I)
- Title 18, United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs and employee misconduct
- Title 42, United States Code, sections 263a(1), 274e, 290dd-2, 300w-8, 300x-8, 707, 1320a-7b, the Social Security and Public Health Service Acts

Civil and administrative investigative authorities include civil monetary penalty and exclusion authorities such as those at:

- Title 31, United States Code, sections 3729-3733, (the False Claims Act) and 3801-3812 (the Program Fraud Civil Remedies Act)
- Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

